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An Assessment of Round-Table Psychotherapy[1]

William H. Cadman, Lorenz Misbach, and Donald V. Brown

The University of Kansas City

THEORY AND PURPOSE

THE ROUND-TABLE method of group psychotherapy was first formulated in 1949 by Willis H. McCann, at Missouri State Hospital No. 2, St. Joseph, Missouri. The original round-table method and the results from its first year of use are reported by McCann and Almada (4).

In the succeeding year the method was given further trial and was modified in some important respects by Dr. McCann, Mr. Cadman, and Mr. Brown. This revised method, which is described in the next section, was followed during the early part of the work to be reviewed here. The latter part of the experimental period involved trial of some further modifications of method. These modifications are also described in the following section.

Since any therapeutic endeavor involves assumptions about the nature of mental illness, we believe that an attempt to state our assumptions explicitly should precede statements concerning purposes, procedures, and results. Broadly speaking, the primary assumption underlying our procedure is that mental illness, insofar as it is not the result of organic impairment, arises primarily from and within the *interpersonal relationships* of the individual, i.e., the individual is mentally ill when he is unable to acquire or to maintain satisfying relationships with significant persons in his environment. Mental illness occurs when the expectancies of the individual create anxiety of such extent and locus as to prevent the satisfaction of basic "organismic" needs. The expectancies brought to interpersonal relationships produce and intensify anxiety to such an extent that frustration becomes inevitable. In addition, anxiety and frustration in mental illness result in behavior patterns which are "illogical and irrational" in the sense that they make the

[1] This study was made possible by a research grant from the U. S. Public Health Service. During the academic year 1951-52, research was conducted at State Hospital No. 2, St. Joseph, Missouri, under codirection of Dr. Willis H. McCann and Mr. W. H. Cadman. During 1952-53, the location of work was at General Hospital No. 2, Kansas City, Missouri, under codirection of Dr. Lorenz Misbach and Mr. W. H. Cadman. Invaluable psychiatric and administrative assistance was given during the first year of work by Dr. Orr Mullinax, Superintendent of State Hospital No. 2. The following members of the staff of General Hospital No. 2 contributed essential assistance during the second year of the study: Dr. E. Frank Ellis, superintendent; Dr. Bruce McDonald, resident physician; Dr. Herbert Shuey, staff psychiatrist; Miss Vivienne Black, supervisor of medical social services; Mrs. Sarah Watson and Mrs. Cora Dougherty, nurses in psychiatric wards.

Much work of psychological character was done by the following persons: Dr. Alex Sweet, member of the faculty of the University of Kansas; Mrs. Phyllis Printz, member of the staff of the University of Kansas City; Mr. James McCann, Mrs. Barbara Edmonson, Mrs. Elizabeth Vance Fitzhugh, Mr. David Quick, all of whom were research assistants and graduate students in psychology at the University of Kansas City; Mr. Winton Ahlstrom, Mr. Loren Fitzhugh, Mr. Robert Piltz, and Mr. William Kelly, also graduate students in psychology at the University of Kansas City.

attainment of need-satisfaction increasingly difficult, if not impossible. The individual may also be said to behave "illogically and irrationally" because the constant high level of anxiety tends to prevent him from examining and viewing his "interpersonal field" in new and varying perspectives which could be expressed in appropriate revisions of behavior patterns.

The preceding statements obviously invite questions concerning the nature of the developmental failures which may underlie, or account for, handicapping anxiety in interpersonal relationships. With Fromm-Reichman we would define anxiety as "the discomfort which the child learns to feel in the presence of the disapproval of the significant adult who first arouses this discomfort while training the child to abide by the basic requirements of acculturation" (2, p. XI). We assume that hindrance of acculturation is produced by this "early discomfort," and that consequent impairment of development may involve failure to acquire a set of values and needs realistically oriented to the subculture in which the individual is required to function, failure to apprehend adequately the "common phenomenal experiences" which characterize his subculture, and failure to acquire commonly accepted and meaningful social responses.

If the individual has failed to acquire a "realistically" oriented set of values and needs, discrepancies between his wants and the wants of others, both as to hierarchical order and content of wants, will set him apart from his group. To be thus set apart prevents development of an adequate sense of belongingness, so that the individual does not feel himself to be accepted by others. He is unable to form positive social relationships with sufficient readiness so as to fit comfortably within a group. The individual is therefore handicapped in his efforts to acquire new experiences which might enable him to alter his values and expectancies in terms of those prevailing within his social orbits.

If the individual has failed to apprehend adequately the common phenomenal experiences which characterize his subculture, his ability to communicate will be handicapped. The degree of his handicap will be proportionate to the uniqueness of his "phenomenal meanings" for the emotional experiences, language symbols, and objects prevailing in his culture. In our conception, communication may be briefly described as a process of transmitting appropriate cues and responding appropriately to the cues of other individuals in a continuous endeavor to approach satisfaction of needs. But communication can be adequate (need-satisfying) only to the extent that there exists a common phenomenal understanding of the "experiences" to be communicated and of the cues, and responses to cues, appropriate to these experiences. Hence, the greater the common phenomenal understanding, the greater the ease and adequacy of communication, and vice versa.

Failure to acquire a commonly accepted and appropriate set of behavioral responses, for use within social situations, prevents the individual from making his intentions understandable to others. Inability to respond appropriately to social cues also deprives the individual of opportunity to elicit from others continuing attempts to communicate their motives. Thus, attainment of mutual comprehension of motives, without which behavior is in considerable part desocialized, is very much dependent upon utilization of skill in responding to social cues.

From consideration of the preceding assumptions, we derive the proposition that effective psychotherapy must enable the individual (*a*) to reorient his needs and values in the formation of positive interpersonal relationships, (*b*) to extend and improve his ability to communicate through improvement in his understanding of a "commonality of experience," and (*c*) to increase his ability to utilize an effective variation of responses to social cues. It seems to us that exceptional opportunity for attainment of these objectives may be provided by the round-table group situation.

In round-table procedure, participants are given responsibility for working together democratically toward goals which are predefined, but not demanded. In such a situation the paralyzing effects of

anxiety may be sufficiently reduced so as to permit the individual to experiment in relative safety with variations in attempts to achieve socially useful interpretations and modes of action. Various features of round-table procedure are designed to structure group activity in such a way as to encourage continuing search for explanations and for further solutions of behavior problems. Participants may, therefore, be impelled to substitute problem-solving attitudes for problem-avoiding attitudes. We assume that analysis of any problem of interpersonal relationships will suggest a number of possible solutions, and that among these one or more will be usable by an individual with a minimum of social skills. More specifically, the individual participating in round-table group sessions should benefit from attempts to interpret the personal histories offered by other members, and from attempts to communicate an account of his own problems and behavior. It is to be expected that from these endeavors the participant will gain insight into the feelings and motives of others, and, in proportion to his identification with other group members, he should also gain insight into his own behavior. Insofar as the round-table sessions impel members to continue efforts to understand and to be understood, and to verbalize their interpretations, the participant may discover techniques for promoting continuation of discussion and may gain ability to communicate attitudes and interpretations which are under continuing evaluation with respect to their realism. Very importantly, the participant should learn to perceive more adequately the similarities and dissimilarities between himself and others, so that he may eventually arrive at understanding of the generalization that "we are all much more simply human than otherwise, be we happy and successful, contented and detached, miserable and mentally disordered, or whatever" (8, p. xviii).

It was expected that evidence obtained in this study would contribute to progress toward accurate assessment of the general therapeutic effectiveness of round-table procedure. A further purpose was to evaluate some component phases of the procedure. But our primary purpose was to explore the extent to which, and the manner in which, the social context of round-table sessions incorporates processes which, on theoretical grounds, we believe to be therapeutically essential. These processes, as they have been indicated in preceding paragraphs, are: (*a*) development of positive interpersonal relationships, (*b*) development of ability of individuals to participate actively in the flow of communication between members of the group, and (*c*) trial of various modes of response in the acquisition of social skills. It was hoped, also, that clues would be obtained concerning changes in level of anxiety on the part of round-table participants, and concerning the role of these changes in social processes.

POPULATION AND PROCEDURE

Subjects

State hospital patients. Subjects for the first year of this study were patients who had been adjudged "insane" and committed to Missouri State Hospital No. 2. Seventy patients in all were utilized. Of these, 12 were admitted to the hospital after the study began.

No diagnostic categories were excluded from the study with the exception of those in which there was demonstrable organic etiology and those in which feeblemindedness seemed to be a primary factor. Duration of illness was ignored in selection of subjects.

The specific characteristics in terms of which we selected patients for the study were: age—17 to 53 years; education—fifth grade through college; intelligence—above the moronic level; diagnosis—any in which there was neither demonstrable organic involvement nor evidence of mental deficiency as a primary factor.

The total group of patients was subdivided into a male and a female control group and a male and a female experimental group. Preliminary efforts were made to match these patients as closely as possibly on the basis of age, education, and intelligence, but this matching procedure was found to be impracticable. The population was therefore divided into control and experimental groups on the basis of chance selection.

Original experimental groups numbered 12 men and 18 women. Original control groups numbered 10 men and 18 women. Additions to the original female groups were obtained from new admissions to the hospital and were randomized between the experimental and control groups. The first newly admitted female patient who met the criteria stated in the preceding paragraph was placed in the experimental group, the second such patient was placed in the control group, and so on. Because of the small number of new male patients who met the criteria, all who did meet them were placed in the experimental group. Final totals were: in the experimental groups, 17 men and 21 women; in the control groups, 10 men and 22 women.

Upon examining the group composition we found that the age range for the control groups was from 20 years to 53 years, with a median age of 36 years, and for the experimental groups the range was from 17 to 51 years, with a median age of 36.5 years. The range of Wechsler-Bellevue IQ's for the control groups was 52 to 120, with a mean of 86.7, whereas for the experimental groups the range was 55 to 124, with a mean of 93.8. Level of education ranged for the control groups from grade 5 to grade 13, with a median of 11, and for the experimental groups the range was from grade 5 to grade 16, with a median of 10. The duration of illness for the control groups was from 5 months to 198 months, with a mean time of 62.9 months. For the experimental groups the range was from 2 months to 207 months, with a mean of 62.3 months.

Diagnostic classifications of patients, as determined by Dr. Orr Mullinax, Dr. Willis H. McCann, and Mr. William H. Cadman, were: in the control groups, 25 patients described as schizophrenic, 3 as exhibiting paranoid conditions, 1 as exhibiting a postpartum psychosis, 1 psychoneurotic, 1 manic, and 1 depressive; in the experimental groups 25 patients were described as schizophrenic, 3 as exhibiting alcoholism with psychosis, 2 as exhibiting paranoid conditions, 2 as exhibiting psychopathic personality, 3 described as depressive, 1 manic, 1 involutional, and 1 as exhibiting reactive depression. The majority of schizophrenics in both groups were judged to be paranoid types.

City hospital patients. The second year of the study was conducted at General Hospital No. 2 (for Negro patients only) in Kansas City, Missouri. It is the policy of this hospital, as a city hospital, to treat only those patients who show possibilities for recovery within a short time and to order commitment for those who need long-term treatment. As a result of this policy, and because patients are not under commitment in a city hospital, some of the standards of procedure and of patient selection which we exercised in the first year of the study were not possible. Also, no control groups were used.

Every patient on the psychiatric wards who could be persuaded to join a group in the therapy room participated in group sessions, regardless of age or diagnosis. This procedure was virtually required by the small number of patients available at any one time. It was also in harmony with our belief that responsiveness of patients to psychotherapy is less a function of the type of illness or of the etiology of the illness than of the ability of the patient to establish a relationship with a therapist. A total of 63 patients, 28 men and 35 women, participated in the group sessions. The range of number of sessions attended was from 6 to 26.

For each patient a case history was obtained by the Medical Social Service and a psychiatric examination was made by the attending physician. A battery of psychological tests was also administered to all patients who would respond in the test situation. After this examination period, a staff session was held at which diagnosis was made and treatment plans were formulated, patients being referred to the group therapy sessions if, or as soon as, they could be led to participate, unless commitment was recommended. Even when commitment had been ordered for a patient, he ordinarily participated in the group sessions while awaiting transferral to a state hospital.

The intelligence range of these patients was from 50 to 115, with a median of 78. The range of the educational level was from the second grade to college, with a median of 9 years.

Diagnostic classifications, as determined by the staff, described 35 patients as schizophrenic, 5 as manic, 4 depressive, 15 paretic, 3 senile, and 1 as exhibiting acute alcoholism.

Procedure in Work at the State Hospital

The therapy room. All therapy sessions were held in a "classroom" which was a part of a larger room. The classroom was enclosed on three sides and on the ceiling by dark red and soft gray drapes. These drapes served the following purposes: (*a*) they prevented extraneous noises from being recorded; (*b*) they reduced the stimuli which might distract the patients; and (*c*) they set this room apart from the rest of the drab hospital surroundings. At one end of the room was a one-way mirror through which the patients could be observed. The other room furnishings were a battery of signal lights, a microphone suspended from the ceiling, a speaker box, an electric clock (which was requested by the patients), and a "round table."

Orientation sessions and organization of groups. At the beginning of the experimental period at State Hospital No. 2, an orientation period was held for each of the experimental groups. Evidence reported by Powdermaker and Frank (6, pp. 51 ff.) indicates that expectations and attitudes created, or modified, in orientation sessions may have determined in considerable measure the later course of group activities.

The patients were informed that each of the group sessions would be recorded and that these recordings would be played back to them at the beginning of the next therapy session. The patients took pride in "being on the air," although occasionally they waited until the session was over before mentioning some particularly "dangerous" material.

In the orientation period the patients were asked if they wished to have anyone in the room with them during the group sessions or if they would prefer to manage the sessions themselves. As we had antici-

pated (and wished), the patients elected to have all hospital personnel wait outside the room. Every effort was made to allow the patients to decide upon their own rules and regulations and the manner in which these were to be enforced. The therapists avoided imposing their own wishes except in insisting upon silence during the playback, and in setting forth the routine and theory of the group procedure. The rules and regulations which the patients felt to be important were enforced by the staff.

It was explained to the patients that these sessions were serious matters, providing patients with an opportunity to re-examine their own lives and problems, to discuss freely anything which was of importance to them, and to find solutions to the important problems which they had to face.

It was emphasized that recommendations of the round-table group would be of major importance in staff decisions concerning release of patients from the hospital. It was explained that once the group voted a member to staff, the staff would decide on the disposition of the case. If the patient was well enough, he would be sent home; if he was not well, he would be returned to the group.[2] It was also explained that recommendations to staff were to be weighed carefully because the recommendations would be of importance in enabling the staff to judge the "normalcy" of those voting the patient to staff, as well as the fitness for release of the patient referred. If an obviously unwell patient were recommended for parole, the staff would have to conclude that the group showed defective judgment, and if an obviously "improved" patient were not recommended to staff, this also showed defective judgment. We emphasized that the patients with their constant and varied contacts would have had a better opportunity to observe the ward behavior of any group member sent to staff than the doctors could have had, and as a consequence, we would rely upon them to utilize their information concerning such behavior.

One further point was brought up by one of the patients, who asked about the procedure for being sent to a state hospital. This procedure was explained carefully and it was pointed out that only individuals who were mentally ill were brought to mental hospitals, and that no one had been "framed."

In summary, the orientation session stressed the following points: (*a*) explanation of the procedure for admission and release from hospitals; (*b*) the patient's responsibility for his own improvement and release; (*c*) the conception that among the criteria of normal behavior are the ability to manage one's own affairs and behavior, to maintain reasonable

[2] The round-table groups were to proceed for one year on the basis of the plan outlined in this section. At the end of the year the groups were to undergo complete reorganization. In operation, the plan of procedure may have tended to produce progressive weakening of the effectiveness of round-table sessions after the first month or two. Within two months after the sessions began, 3 male patients and 2 female patients had been discharged from the hospital via staff action following recommendations of the round-table groups. Not all of the vacancies thus created were filled by participants as able to contribute as had been the "graduates." But the trend thus produced, toward weakening of the round-table group, was at least in part offset by improved ability to contribute of some participants who did not win discharge. We would nevertheless suggest that round-table procedure should be supplemented by individual therapeutic work with those who are apparently nonresponding participants, and that this individual assistance should include efforts to achieve nontraumatizing removal of nonresponding patients from the round-table group.

contact and relationships with others, and to accept the responsibilities connected with social relationships; (*d*) the view that unless the patient was willing to face his own problems and attempt to solve them, we could not help him—that we could not cure patients but could only help them to help themselves.

The total population of the experimental wards for men and women elected round-table members for each of the two experimental groups. The seven patients who received the highest number of votes became the initial round-table participants. Other members of the ward constituted a studio audience present at all group sessions. From this time on, the conduct of the group was managed by the round-table members. They recommended individuals from among their membership for release, selected new members for the table when a position was vacant, voted members away from the table, and regulated the behavior of all patients while in the classroom.

The priming session. Just before each group session each round-table member was given a ten-minute "priming session" by a therapist (Dr. McCann or Mr. Brown). The priming session was held in the therapy room and was recorded. Only the therapist and the patient being "primed" (hereafter referred to as the "primee") were present in the classroom during the priming session. Notes were made by one of the staff members, sitting behind the one-way mirror, during the recording of each priming session. These notes provided information about the patient which was often useful at later dates.

The primee was encouraged during the priming session to discuss the other patients at the table, to give his conclusions and ideas about the problems and progress of the other patients, and to express his opinion about the previous sessions. Information was given about such matters as commitment procedures, the nature of mental health or mental illness, and the theory of group treatment. One particularly important procedure followed by the therapist was to encourage the patient to take his annoyances and hostilities back to the group sessions.

In advance of each series of priming sessions for a given group session, one of the round-table participants was chosen by the staff as the prospective "target" patient for the forthcoming session. This choice was made without formal action by the round-table group, and without formal notification of the patient chosen. But round-table members were usually questioned casually on the ward as to whom they wished to question at the next session, and staff choice seldom differed from choices expressed by patients when there was any considerable agreement among round-table members. Usually the primee would himself suggest the target chosen, in response to questions by the therapist as to which member of the round-table group should be questioned. The therapist tried to interest the primee in the apparent problems of the target patient and in his observable attempted solutions of these problems.

Originally we had supplied primees with case material about target patients, but experience soon led us to see that this case material was relatively unimportant and sometimes led the primee into fruitless questions about whether this or that was true. Such questions tended to interfere with the process of perceiving and responding to the feelings of the patient. After one or two experiences with this type of "intellectualizing" we withheld information unless it was spe-

cifically requested and accompanied by a statement of adequate reasons for the request. Our purpose was to encourage the primees to think about the behavior of the target patient and to bring out as much as could be recalled of the irrationality of the present behavior of the target patient. The primee was also encouraged to use every means possible to get the target patient to "tell his story" and to persuade the autobiographer to look at the illogicalities and inconsistencies in this story. In addition, the primee was encouraged to ask the autobiographer what he thought his own part in causing these things might be.

The therapist raised questions about several, or all, members of the round-table, but in general left with the primee responsibility for pursuing the problems of any individual if he wished to do so. If the primee did not exhibit interest in the problems of the target patient, the therapist was compelled to use various suggestions in an attempt to evoke interest. Problems of the primee were avoided as far as possible.

Group sessions. The group therapy sessions were held three times weekly except during vacation periods when the usual hospital routine suffered some interruptions. All patients on the experimental ward, except those who were too ill to attend, came to the therapy room. After they entered, the door was closed. At no time was there an attendant or staff member in the room with the patients.

One of the primary reasons for excluding hospital personnel from the therapy room was our feeling that the presence of attendants limited the expressions of the patients. This was rather vividly verified by a male patient who had been in state hospitals for over fifteen years. When asked, during a priming session, why he did not talk in "group," he replied, "The attendants don't want you to talk, move around, or in any way disturb them." A second reason was our feeling that the presence of any so-called normal individual in the room would encourage the patient to sit passively and wait for someone to "cure" him. A third reason was our feeling that absence of any staff member put the patients in the position of having to assume responsibility for group behavior in a "safe" environment. The fourth reason was our feeling that the patient-controlled situation demonstrated to the patient that we had confidence in his ability to handle his own affairs, to integrate himself into a group of his peers, and to cope with the behavior of others. Provision of opportunity and obligation for accepting responsibility also expressed our confidence in the reality of the patient's desire for treatment and in his ability to cooperate in such treatment.

After the round-table members had seated themselves and the studio audience had sat down away from the table, a red light on the ledge of the one-way screen went on. This was a signal for the patients to become quiet and wait for the playback of the previous day's session. Patients understood that during this playback they were to remain quiet. When the playback was completed, a green light (the signal for the patients to begin conversation) flashed on. For thirty minutes the patients were then free to discuss any problems in whatever manner they might desire. At the end of thirty minutes, regardless of the group activity, the red light went on and the green light went out, and conversation ceased. The sessions were not interfered with by anyone unless the patients around the table voted unanimously to have a patient removed from the room, at which point a staff member would enter and remove the patient. Such interruptions occurred very infrequently.

Each experimental group held a total of fifty sessions. The number of sessions attended by individual members of the studio audience varied from 9 to 50. The number of sessions in which an individual patient participated at the round-

table varied from 0 to 50.

Patients on the experimental wards received routine individual medical care, but psychiatric treatment was limited to the round-table method of group psychotherapy. Our original intention was to release our patients from work details, but this was later ruled out as not in accord with inescapable hospital routine.

Patients on control wards received standard hospital treatment, including shock therapy when indicated by symptomatology, occasional recreational therapy, and some individual interviews with psychological interns.

Procedure in the City Hospital

Various modifications of the procedure described in preceding paragraphs were made in work at General Hospital No. 2. Some of these modifications were dictated by exigencies of the hospital situation.

As previously noted, patients in the City Hospital were not divided into experimental and control groups. Such division was not feasible because of the relatively small number of patients available at any one time (seldom more than 15), the briefness of stay in the hospital for many patients, and lack of physical facilities for separate experimental and control wards.

In many of the group sessions there was no studio audience because of the small number of patients able to participate.

Orientation sessions were held as with the groups at the State Hospital, with two important modifications in procedure, viz.: (*a*) because of the relatively rapid patient turnover, the functioning group could not be as much depended upon to orient new patients as was the case in the State Hospital groups, so that it was necessary to depend heavily upon individual orienting advice given to each new patient; (*b*) patients were not told that release would ordinarily be gained via recommendation to staff from the round-table. The patients were, nevertheless, asked to make recommendations to the staff, on the general grounds that such recommendations might be useful.

Some modifications in procedure not required by the situation were deliberately given trial during the work at the City Hospital. Trials were made of omission of priming sessions and of the playback. In some sessions observations were made of the effects of presence of a therapist during group sessions.

Tests, Case Materials, Ratings

In work at the State Hospital, the Wechsler-Bellevue, the Rorschach, the MAPS, and the Szondi tests, were administered to each patient before he was placed in an experimental or control group.

The tests were administered by five graduate students from the University of Kansas City, according to standardized directions. This work was arranged so that ordinarily a given patient saw four different examiners. Each of the examiners administered several or all of the four tests used, but in no case administered all four tests to a given patient. Except for ten cases, (6 from experimental and 4 from control groups) in which patients were unexpectedly released or transferred from the experimental or control wards, the original battery of tests was readministered to each patient at the end of the experimental period or prior to his release, if this occurred during the experimental period.

Each of the tests was scored in accordance with a predetermined method so that analysis of differences between pre-experimental and postexperimental test results could be made in wholly quantitative terms. This quantitative procedure sacrifices a wealth of potentially useful material from test results, but the procedure seemed to us nevertheless to be required for purposes of the present study.

All participating patients at General Hospital No. 2 were given the Wechsler-Bellevue, the Rorschach, and the The-

matic Apperception tests as soon as possible after admission to the hospital. Retests before leaving this hospital were seldom obtained since relatives could and did remove patients without warning.

Complete case histories were in many instances unavailable for patients in the State Hospital groups. We were compelled to be content with such facts as we could obtain from hospital records and from interviews with visiting relatives. The L-M Fergus Falls Behavior Rating Sheet was filled out weekly by nurses and attendants in charge of experimental and control groups. For patients at General Hospital No. 2 very good case histories were supplied by the Department of Social Service.

GROSS RESULTS

Comparison of Experimental-Control Groups

Changes in clinical status. The status of patients at the end of the first year of work at State Hospital No. 2 is shown in Table 1. In compiling this table the designation "improved" is limited to those patients who at the completion of the experimental period or at the time of discharge were considered to have lost their hallucinations and delusions, to have developed controls over their violent reactions, to have shown improvement in personal habits and appearances, and in general to have shown some possibility of release without probability of return.

The designation "unimproved" is limited to those patients who showed no significant progress in socialization, whether or not hallucinations and delusions ceased to be a major problem. Essentially these were patients in whom little or no change in pre-experimental symptoms could be observed.

Discharges are listed under both improved and unimproved categories. Under improved are those the staff felt were ready for a return to society and for whom this return was expected to be a permanent one. Under unimproved are those who were released with the expectation that their return to society would be for a short time only and those who were

TABLE 1

CLINICAL STATUS OF PATIENTS AT END OF FIRST YEAR: STATE HOSPITAL NO. 2

Clinical Status	Experimental		Control	
	Male	Female	Male	Female
Improved—not discharged	3	6	0	0
Improved—discharged	10	5	1	3
Total improved	13	11	1	3
Unimproved—not discharged	3	8	8	13
Unimproved—discharged	1	2	1	6
Total unimproved	4	10	9	19
Total	17	21	10	22

Note.—Comparison of experimental and control groups with respect to proportions of improved and unimproved patients yields a χ^2 of 20.23. The greater percentage of improvement in the experimental groups is significant above the .01 level of confidence.

taken by relatives from the hospital against medical advice.

It is evident that the incidence of improvement was much greater for the experimental than for the control groups. Of 17 men in the experimental group, 13 were rated as improved; of 10 men in the control group, only 1 was rated as improved. Of 21 women in the experimental group, 11 were rated as improved; in the control group of 22 women, only 3 were rated as improved.

The reader will realize that data of this kind cannot be regarded as providing a simple measure of the effectiveness of a therapeutic method, per se. Some incidental factors are inevitably involved. Of these, the most important may be the encouragement given to some patients in experimental groups merely by virtue of their awareness of being participants in an enterprise in which staff members have great interest. It must be remembered, also, that staff judgments of improvement are necessarily qualitative. We believe, however, that the incidental factors of importance in this study are merely those generally found in attempts to assess results, in terms of final clinical status, from use of any therapeutic method.

Twenty months after the period covered in data presented in Table 1, a check of the records of State Hospital No. 2 was made, with reference to the hospital status of the patients in experimental and in control groups. This check showed that at the time when the check was made: (*a*) of the 15 patients discharged from experimental groups as improved, none had returned to the hospital; (*b*) of the 20 patients in experimental groups who had not been discharged in the period covered in Table 1, one was on parole and 4 had been discharged; (*c*) of the 21 patients in control groups not discharged in the period covered by Table 1, one was on parole and one had been discharged.[3]

Changes in test scores. The results shown in Table 1 are given further meaning by comparison of test-retest differences for experimental and control groups.

In Tables 2 and 3 are shown differences on these tests between scores at the beginning and at the end of participation in the experiment for all patients for whom data were complete in the experimental and control groups studied in State Hospital No. 2.

For purposes of the comparisons shown in Tables 2 and 3, tests were scored in accordance with routines agreed upon in advance by the experimenters. The Wechsler-Bellevue was scored according to Wechsler's manual (9). Methods of tabulation prescribed in the Klopfer and Kelley manual (3) and Make-A-Picture-Story manual (7) were followed for scoring the Rorschach and the MAPS tests. Responses of subjects to the Szondi cards are not here reported because they cannot, we believe, be meaningfully presented in quantitative comparisons.

Minus numbers in the first two columns of Table 2 indicate mean decreases in scores from test 1 to test 2; positive numbers indicate mean increases in scores from first to second testings.

On the Wechsler-Bellevue test the ex-

[3] Data reported from the check of hospital wards mentioned above are subject to all the uncertainties usually prevailing in such information. Patients may be discharged for reasons other than their improvement. Discharged patients may have been admitted to other hospitals without knowledge of the staff of State Hospital No. 2. Ratings of improvement or nonimprovement, for patients who had not been discharged, could be of little or no meaning, and were not attempted; such ratings can be meaningful only when made by a staff in continuous contact with the patients rated, during the course of work providing consistent bases for ratings.

As is indicated in a later section, we were able to obtain reliable information one year after completion of the experimental period concerning seven patients who were discharged as improved from the experimental groups. All of these patients were reported to be succeeding in adaptation to nonhospital environments.

Further indications of the probable durability of gains achieved in the course of round-table psychotherapy are provided by comparisons of results of initial and terminal administrations of tests.

TABLE 2

DIFFERENCES BETWEEN MEAN TEST SCORES FOR ORIGINAL AND SECOND TEST ADMINISTRATIONS FOR WECHSLER-BELLEVUE AND RORSCHACH TESTS

Wechsler-Bellevue					Rorschach				
Item	D_E	D_C	D_E-D_C	CR	Item	D_E	D_C	D_E-D_C	CR
Info.	22	6	+16	4.62	*M*	9	−10	+19	6.55
Comp.	−11	−27	−16	2.55	*FM*	− 1	− 8.5	− 7.5	2.23
D. Sp.	−47	−44	+ 3	.51	*m*	.5	− 6	− 6.5	3.59
Arith.	1	− 8	− 9	1.55	*k*	− 7.5	− 2	+ 5.5	4.51
Sim.	23	0	+23	4.73	*K*	− 1.5	10.5	−12	10.26
Voc.	− 7	−29	−22	5.37	*FK*	.5	1	− .5	.36
P. A.	28	36	− 8	1.24	*F*	−15.5	−57	−41.5	31.92
P. C.	25	14	+11	2.08	*Fc*	−19	−21.5	− 2.5	.63
B. D.	40	26	+14	2.28	*c*	−11.5	− 5.5	+ 6	2.75
O. A.	10	8	+ 2	.28	*C'*	−10	− 8	+ 2	1.14
D. Sym.	35	0	+35	8.37	*FC*	− 2.5	− 9.5	− 7	3.04
Verb.	−12	−74	−62	41.61	*CF*	− 7.5	−16	− 8.5	3.28
Perf.	131	78	+53	2.75	*C*	−10.5	− 8	+ 2.5	1.04
Total	119	26	+93	3.33	Resp.	158	133	+25	13.10
					Rej.	3	37	−34	7.75

Note.—D_E=Mean difference for experimental group (N=32).
D_C=Mean difference for control group (N=28).

perimental group shows a comparative gain significant above the .01 level of confidence in information, similarities, digit symbol, performance IQ, and total IQ, and comparative gains significant above the .05 level of confidence in picture completion and in block design. The control group shows significantly greater loss in vocabulary and total verbal IQ, above the .01 level of confidence, and a comparative loss in comprehension above the .05 level.

On the Rorschach test the experimental group shows comparative gains above the .01 level of confidence in *M* and in total responses, and shows comparative losses above the .01 level of confidence in *k*, *K*, and in *c*. The control group shows comparative increases above the .01 level of confidence in the number of rejections and in *K;* comparative losses above the .01 level of confidence are shown in *m*, *F*, *FC*, and *CF*, and a comparative loss above the .05 level of confidence in *FM* is shown.

On the Make-A-Picture-Story Test (Table 3) the experimental group showed an increase in normal signs while the control group showed a decrease in normal signs, the difference being significant above the .01 level of confidence. On the schizophrenic signs the control group showed an increase and the experimental a decrease, the difference being significant above the .01 level of confidence.

From test results it would appear that our average experimental patient shows significant gain in the course of the round-table procedure in normal characteristics. He appears to exhibit decreasing over-all repression, to gain awareness

TABLE 3

DIFFERENCES BETWEEN MEAN TEST SCORES FOR ORIGINAL AND SECOND TEST ADMINISTRATIONS FOR MAPS

(Experimental group, N=32; control group, N=28)

Signs	Exper. Group	Control Group	*D*	CR
Normal	15	−14	29	5.41
Schiz.	−22	8	30	8.85

Note.—CR of 2.0=.05; CR of 2.6=.01.

and acceptance of his own basic impulses, and to show less uncontrolled sensuality and impulsiveness. Increased ability to investigate and to respond to the world around him are also indicated. He gains in ability to investigate the inconsistencies of his environment and becomes less prone to reject stimuli without having examined them. He is better able, at the end of his experience in the group work, to acquire and to express facts and knowledge, and to collect and organize meaningfully the relevant information necessary for making adequate judgments. He is generally less concretistic in his reasoning than when he entered the group, and is more able to discover the likenesses and differences between objects and concepts. "Free-floating" anxiety seems to be reduced, and feelings of being pushed by the environment are less operative.

Modifications of personality functioning indicated by test results do not appear to be merely superficial in nature. Their character justifies the expectation that they will be durable, and that they will enable the individual to progress in socialization unless his social milieu becomes highly unpermissive.

Changes in ward behavior. Observations of ward behavior were in harmony with the gross outcomes indicated in Tables 1 and 2. There was, very evidently, in the experimental groups the development of a group *esprit de corps,* which imposed on patients an obligation to prevent disruptions of harmony on the ward. If a patient became disturbed, others sought to quiet him by sympathetic communication. Individual patients in the experimental groups, including many of those not listed in Table 1 as improved, showed increased social awareness on the ward. Some who had previously refused to communicate became able to do so, at least within limits. There was also increased interest in reading.

The Significance of Various Components of the Round-Table Procedure

We cannot pretend to have explored all the possibilities of application of the round-table method to city hospital situations, but our experience leads us to believe that such an application will require a great deal of skillful search for means of effecting necessary modifications of the procedure without sacrifice of its essential components. The attempt to apply the procedure was, in our judgment and in the judgment of members of the staff of the City Hospital, of material benefit. Among other benefits, nurses and other hospital staff members gained increased confidence in possibilities of dealing permissively with psychotic patients.

Our exploration of results from variation of several component features of the round-table procedure was, during the second year of work, in some instances forced upon us or indicated by difficulties inherent in the City Hospital situation. In addition, we deliberately made trial of some variations.

Importance of prescription of round-table participation as a route to release. It has been stated that in our work at State Hospital No. 2, the importance of round-table recommendations for gaining release was emphasized in orientation sessions. Content of the group sessions contains abundant evidence that this advice played a major role in the motivation of round-table participants. In the City Hospital situation the incentive of gaining release through favorable actions of the patient group could not be offered. Patients were advised, as in the State Hospital group, that the group sessions

provided opportunity for participants to understand their problems more adequately and to find solutions to these problems. These less tangible, or more truly "psychological," persuasions did not seem to compensate for lack of the more tangible incentive of release via the group sessions. Although in our judgment some of the group sessions in the City Hospital were admirable, there was on the whole a relative lack of continuity of group organization and effort. Many patients who were apparently no less able to participate than many in our State Hospital experimental group refused to assume a responsible role in the group sessions.

Effect of presence of therapist. It seemed to us possible, at one point in the second year's work, that the presence of a staff member during the group session might provide an essential stabilizing influence. Our experience indicated that if a psychotherapist is present he is compelled by the situation, as Powdermaker and Frank observe (6, pp. 318 ff.), to assume very difficult leadership functions. The resultant therapeutic process is therefore essentially different from the round-table method as characterized earlier in this paper. The therapist in the group situation incurs problems of transference which may be more complex than those arising in individual psychotherapy (6, p. 393). Patients seek to depend upon him, to be guided by him, to vent hostilities upon him, and to compete for claims upon him.

Effect of priming sessions. A major difficulty in the City Hospital situation was the lack of opportunity for patients to form, in the ward, a significant degree of group organization. Because of this lack, as well as for others reasons, it was at best difficult to use priming sessions for the purpose of directing group interest and inquiry upon the problems of a target patient. We therefore tried a procedure involving no priming sessions. The results, in general, seemed to indicate that although the value of the priming session in the City Hospital situation was limited, its absence brought about almost complete collapse of any group effort directed toward exposition of problems of participants. Without the priming session the group periods tended to become merely "bull sessions."

The function of the studio audience. Because of the relatively small number of patients available at any one time for participation in group sessions in the City Hospital, all participants were usually placed at the "table," leaving none to constitute a studio audience. It seemed to us that this lack of a studio audience imposed a significant handicap upon the group sessions. Some advantages which had seemed to accrue from the presence of the studio audience in the work at the State Hospital were called to our attention when we worked with a group of only six or fewer individuals. It seems pertinent to note here some of the benefits which we believe accrue from the presence of a relatively stable audience.

The studio audience seemed to function as a group background against which the table members stood out, apparently encouraging round-table members to set a good example. Members of the studio audience often were led by interest in the talk of round-table members to ask questions which seemed pertinent to the discussion. In addition, the spectators became acquainted with the round-table technique and thus, if responsive, became prepared for eventual election to the round-table. Also, studio audience members learned that it was safe to

"open up" in the presence of others and to discuss material which had previously been considered unacceptable.

In the opinion of observers, the studio audience in groups at the State Hospital also provided a group opinion which was sometimes different from that characteristic of the table. This climate of opinion seemed to encourage the table members to alter their own attitudes with reference to the opinions of the studio members. A striking example of the interest and attention shown by studio audience members and of the influence which they were able to exercise is shown by the action of a catatonic of long standing, who finally became annoyed at the evasiveness of one round-table member and at the inept questioning going on at the table. She interrupted her usual signalling to an unseen companion, arose, and asked extremely pertinent questions. She managed to force the patient to clarify her statements and to add relevant material where necessary. After the discussion had become, in her opinion, and in ours, more profitable, she sat down and immediately began signalling to and conversing with her unseen friend. This brief movement into reality was effectively used by one of the round-table members as an example for other members to emulate.

Effect of playback. The playback offered the patient an opportunity to hear himself as his story was played back. Since the patient's degree of "reality" orientation varied from day to day, the patient was quite often able to examine his own "irrational" productions while in a rational mood. From the vantage point behind the one-way screen, it was possible to observe patients showing varied signs of surprise, distress, chagrin, agreement, and disagreement, upon hearing their performance in the previous sessions. One patient, whose fluctuations between reality orientation and disorientation were extreme and frequent, remarked, "Oh, I couldn't have said that." At other times, patients would sit and smile, frown unbelievingly, laugh, and even get up and leave the table in an effort to avoid hearing what they had said. Frequent comments of, "that was sillier than hell," "he must be nuts," "I'm not going to sit here and listen to that," and in one instance, "no wonder they brought me here," were heard. Quite often the playback seemed to accentuate some issue which could be discussed in the following session. Omission of the playback seemed to us, in such trials as we made, to impair the continuity of group effort and to decrease the probability of continuous progress by individuals.

ANALYSIS OF GROUP SESSIONS

Methods of Analysis

All round-table sessions were recorded on tape, and from these recordings verbatim transcriptions were typed. These transcriptions should yield, if effectively analyzed, important evidence concerning the dynamic processes involved in the form of group psychotherapy under investigation. Much effort was exerted in attempts to achieve useful analysis of the group sessions.

Various methods of analysis were tried and abandoned as unsatisfactory for use with our materials. Among these were attempts to order transcribed records, or components of these records, in terms of:

(*a*) the Discomfort-Relief Quotient used by Dollard and Mowrer (1) in studies of changes in patients through therapy; (*b*) thematic categories similar to those employed by Murray and others (5); (*c*) features of personality structures indicated by test materials; (*d*) proportions of verbal output, for each patient, falling within various topical categories such as hospital and ward life, technique and progress of the group, refusals to assume responsibility, delusionary material, positive statements about self, positive statements about others, negative statements about others; (*e*) count of words per patient and per session to discover total verbal output and proportions of first, second, and third person pronouns. A major reason for abandonment of the first four of these methods was our inability to demonstrate for them a significant degree of reliability. Two or more analysts often obtained very diverse results from analysis of the same materials. Method *e*, depending upon word counts, was reliable, but yielded results which did not appear to be significantly related to other indices of progress of patients toward socialization. We conclude, from the negative character of our experience with the methods mentioned in this paragraph, that they are not usefully applicable to materials such as we had in hand (cf. Appendix C).

From experience with the methods tried and abandoned, we arrived at procedures which may, in general, be described as "direct" in character. A chart was prepared which enabled us to record, for each session, the number of times a patient spoke to another patient or was spoken to, and to record the total number of interactions during the session. From the data obtained in this manner, we were able to make graphs showing directions and amounts of interpatient communications, indicating the readiness or ability of the patient to communicate (i.e., his "communicability") and increases or decreases in communicability from one session to another. By examining the communicability of the patient we were able to draw conclusions as to the degree to which he could interact with the group. We were also provided with clues concerning the relationship between communicability and progress toward recovery (sufficient improvement to warrant release from the hospital).

We also wrote, for each session studied, a summary covering the major features of the sequences of activity and of outstanding features of the session, and judgments were recorded concerning the general atmosphere of the session, the major group activity, the major theme or themes of the session, the role or roles played by each participant, and the attitude of each participant. These judgments were made from holistic impressions gained from reading through the entire transcription of each session. Judges sharing this work were Mr. Brown, Mr. Cadman, Dr. Misbach, and Dr. Sweet. Each transcription was read in toto by two of the four judges. If the two judges disagreed in any respect as to description of the session, the record was re-examined by both judges, in conference with each other, in an attempt to reach agreement. In some instances the agreement reached consisted in including in the final summary of judgments an opinion, by the second judge, which was supplementary to the opinion recorded by the first judge.

The procedures described in the preceding two paragraphs were time consuming, requiring from 5 to 10 man-hours per session, but oc-

casioned no other difficulties of consequence. The directness of the procedure does, however, require lengthy presentation of data if results from analysis of many sessions are reported. But it seemed to us to be neither necessary nor desirable to report results obtained from analysis of all recorded sessions. For the purpose of exploring dynamic processes operative in the round-table sessions, analysis of appropriately chosen sample series of sessions should be advantageous. Fundamental features of the dynamic structure of sessions may be most clearly revealed by analysis of a block of sessions in which there is a minimum of intrusion of fortuitous interruptions or changes in personnel.

We have chosen, for report, analyses of a series of 16 male and a series of 12 female sessions, selected from the total of 100 sessions recorded during the first year of the study with State Hospital patients.

A major consideration in selection of these blocks of sessions was that during them group compositions remained relatively stable. Another advantageous feature of the selected series of sessions is that in each of the two groups the number of patients who were released as improved is approximately equal to the number who did not gain release. Also, the selected series include the complete history of participation of several patients in the round-table sessions. The series selected for analysis begin with initial sessions of the groups concerned, and terminate with the last sessions prior to drastic reorganization of the groups because of simultaneous departure of a number of participants. The selected sessions begin in mid-November, 1951, and cover a period of about one month in the case of the female series and of about two months (with a Christmas-period lapse of over two weeks) for the male series.

Individuals Participating in Sessions Chosen for Analysis

Salient biographic and clinical data; Appendix A. Of the 7 male participants at the beginning of the 16 sessions selected for study, two (H and I) were released from the hospital, via recommendations from the round-table group, at the end of 9 sessions. They were replaced, for the remaining 7 sessions under consideration, by two patients (B and C) from the studio audience (cf. Appendix D). Patient D was compelled, by vote of the round-table group, to return to the studio audience (though he continued to participate actively in round-table discussions) after the twelfth session, but the technical vacancy thus created at the table remained unfilled through the sixteenth session. Thus nine patients were participants, for varying lengths of time, in the series of 16 male sessions under consideration.

All seven original members of the female group continued to participate as round-table members during the twelve sessions chosen for study. Immediately following the twelfth session, the organization of the female group was disrupted by the release of patients Q and S.

The age range for the 16 participating patients was 17 to 47, with an average of 33. Nine of the patients were single, three divorced, one widowed, and three married. Diagnoses classified eleven as schizophrenic, five of these being paranoid, two mixed, two catatonic, and two undetermined as to type. Of the remaining five patients, diagnoses classified two as exhibiting paranoid conditions, one as involutional, one as reactive depression, and one as psychopathic personality with psychosis.

At the end of the year of experimental work, eight of the patients had been transferred to back wards, seven had been discharged, and one was recommended for discharge but did not wish to leave the hospital.

In July, 1953, one year after completion of the experimental period, we were able to obtain reliable information concerning the general status of the 16 participants in the sessions chosen for analysis. This follow-up check revealed no changes, as compared with the status of

patients at the end of the year of experimental work, except that an additional patient, D, had been discharged as improved.

Test-retest data; Appendix B. All but one of the 16 participating patients were available for retesting at the end of the experimental year, or at termination of participation in an experimental group. Test-retest data were recorded separately for each individual. Tables providing these data are available from the American Documentation Institute (cf. Appendix B).

Test-retest differences on the Wechsler-Bellevue are, in general, in harmony with average differences for experimental groups, as shown in Table 2. The number of increases in total IQ is eleven, with three instances of decrease, and one case in which there was no change. The number of increases exceeds the number of decreases in nine of the subtests. Those in which the preponderance of increases over decreases is greatest are: information, 9 increases/1 decrease; digit symbol, 10/2; total performance IQ, 10/4; picture arrangement, 9/4. Decreases exceed the number of increases in the following 4 subtests: arithmetic, 3 increases and 7 decreases; comprehension, 5/8; digid span, 4/6; vocabulary 6/7.

On the Rorschach, decreases in the number of responses having bizarre content and in the number of contaminated and confabulated responses occur in records of 11 patients. A further outstanding feature of Rorschach results is the general prevalence of differences between responses for the initial and the second test administration.

On the Make-A-Picture-Story Test, 9 patients showed increases in normal signs, and 10 showed decreases in the number of schizophrenic signs (7, pp. 189 ff.).

In summary, the major trends of changes occurring in test results are (*a*) increase in total Wechsler-Bellevue scores and (*b*) decrease in number of pathognomic indices in Rorschach and MAPS responses. It is our opinion that these trends reflect reduction of anxiety, increased socialization of responses, and increased ability to communicate, brought about by participation in round-table sessions. This interpretation is supported by the fact that averages for experimental (round-table) and control groups, previously shown in Table 2, indicate that the trends in question appear for experimental groups but are virtually or entirely absent in control group averages. The relatively small average increase in the Wechsler-Bellevue score for control groups indicates that practice effects alone would not account for the magnitude of the trend toward increased scores for round-table participants.

Although we believe that most participants in round-table sessions experience, after a time, reduction in anxiety which permits increased freedom in use of potentiality in responding to the Wechsler-Bellevue, we do not conclude that this must be the case for all participants. Various features of the content of round-table discussions, and direct qualitative observations, convince us that many, or perhaps all, round-table participants must work through increased anxiety in order to arrive at improvement in social organization of behavior involving reduction in anxiety. If this is true, it is to be expected that some patients will not "win through," and may thus exhibit increased anxiety for the duration of their participation in the group sessions. Such persistent heightened anxiety may be reflected in the fact that none of the 4 patients who achieved no gain in total

Wechsler-Bellevue scores from initial testing to retesting (patients B, F, C, R) showed sufficient improvement in behavior to gain release from the hospital. An especially striking instance seems to be provided by the record of patient F, which shows a decrease on retesting in almost every subtest of the Wechsler-Bellevue. This patient was a catatonic of long standing. On the initial test he impressed the examiner with his apparent lack of anxiety. But during group sessions, he rather evidently found it more and more difficult to maintain his initial defensive blandness of manner. At the time of retesting, he exhibited so much anxiety as to impair communication. The Wechsler-Bellevue was administered to this patient a third time, some weeks after termination of participation by the patient in the group sessions. On this third occasion, scores showed a slight increase over results obtained on the initial test administration.

Results of Analysis of Selected Sessions

Sequences and other contents of sessions; cf. Appendix C. The summaries of round-table sessions, presented in Appendix C, cannot convey all aspects of the content of group discussions. But care has been taken, in preparing the summaries, to record an outline of the sequence of events and of major aspects of discussion contents. Striking comments, conflicts between participants, resistance of target patients, efforts to persuade or otherwise influence target patients, are indicated. Reading of the summaries in Appendix C is, we believe, essential for attainment of a ground of acquaintance with many characteristics of the sessions. Interpretations in following pages should, in consequence, be more meaningful than could otherwise be the case.

Perusal of the summaries in Appendix C reveals that both male and female groups were, in the main, guided by the concept of the "target patient." In nearly every session there is persistent effort to explore, during at least a considerable portion of the half-hour period, the problems of some one of the participants. If these efforts fail, or when work which has proceeded for a time with one target patient seems to be balked, the group usually refocuses upon a second target.

Judgments concerning the prevailing atmosphere, the major activities, and the major themes of sessions are given at the end of each summary. These judgments were made, in the manner stated in the section on "Methods of Analysis," on the basis of reading of the entire verbatim transcript of the session.

Atmosphere of sessions; cf. Appendix C. Although some participants in both male and female sessions persistently attempted to promote a positive atmosphere, only in the male sessions were such efforts in the main successful. For ten male sessions the predominance of attitudes of positive character is indicated by descriptive application of one or more terms such as friendly, supportive, sympathetic, helpful, cooperative, concerned, interested, permissive. In contrast, the prevailing tone of the female sessions included some evident admixture of hostility. In only three of the female sessions was there a clear predominance of friendliness or other positive attitudinal atmosphere. It seems to us probable that the trend toward hostility in female sessions may be partially accounted for by the heavy concentration of paranoid patients in the female group (four of the seven participants were so diagnosed, as compared with three of nine participants

in the male sessions; cf. Appendix A). But a more important factor may be the circumstance that the female group had in patient Q a member who functioned in a critical and aggressive manner while maintaining an active role involving an important share in leadership responsibility.

The prevailingly positive atmosphere of the male sessions was disrupted only when D attempted to monopolize or to pressure the group, or to act out his intense hostility toward B. These activities of D were resisted by the group with expressions of irritation. After extended, and on the whole remarkably patient, endeavor to restrain D, he was voted away from the table, in session 13. Exasperation was also expressed with B's insistence upon relating delusional material, and with D's discussions of sexual impulses and of delusions. But a positive atmosphere was always maintained while an individual patient related his personal and familial history and gave an account of his illness and of his hospitalization.

Participants in the female group were as a rule given less freedom during presentation of autobiographies than was permitted in the male group. The autobiographer was often interrupted by questioners, and questions and comments were frequently critical in character. As previously suggested, this relative lack of sympathy and tolerance in the female group may have been at least in part produced by the persistently inquisitorial activity of patient Q. This participant effectively attacked individuals who failed to answer her questions, and also attacked the group as a whole when activity did not proceed, or gain redirection, in accordance with her demands. Factors other than the inquisitorial functioning of Q may underlie an apparently low level of group solidarity in the female group, as compared with the male group. Observation of the female sessions under consideration often suggested that each participant was determinedly pursuing some private objective, at the expense of genuine interest in the problems of others.

It must be added that observations of sessions other than those reported upon here do not convince us that there is a reliable sex difference, as such, in round-table sessions. Adventitious factors apparently obscure, or outweigh, any trend toward sex differences, if such a trend exists.

In our opinion, the most important conclusion to be drawn, from the differences in prevailing atmosphere for the two groups reported upon here, is that therapeutic usefulness of round-table sessions is *not* directly dependent upon the positiveness of attitudinal atmosphere characterizing the sessions. So far as we can judge from study of the sessions in question, the critical, impatient, more or less hostile, atmosphere characterizing the female sessions did not make these sessions therapeutically ineffective. Nothing in our more extended observations, not here reported upon in detail, contradicts this conclusion. It seems to us to be indicated that the effectiveness of round-table therapy is a function of social "working over" of the problems of the individual, and that this process may occur within a wide range of attitudinal milieus.

Major activities during sessions; cf. Appendix C. The major activity of both male and female sessions had to do with eliciting, listening to, and exploring autobiographic accounts. In general, the target patient was asked to tell his story and either during the relating of it or after completion of the account, he was questioned about his relationships with the significant figures in his environment, i.e., his parents, siblings, friends, spouse, children. Attempts were made to discover the attitudes of the target patient toward these significant figures, his feelings for them, and their reactions to him. His adjustments, problems, and reactions to problems were discussed, and suggestions were offered in an attempt to enable the autobiographer to clarify and to re-evaluate his problems and his modes of dealing with them.

Activity of both groups included efforts to produce changes in the behavior of target patients on the ward and during

round-table sessions. The target patient frequently requested information concerning the effect of his behavior on other members of the group, and asked for suggestions which he could use in altering his behavior.

Major activities of the female group involved more active pressuring of autobiographers than appeared in the male group. There was also present throughout female sessions a continuing endeavor to restrain the attacking approach of Q. These efforts to restrain Q frequently took the form of competition for leadership, but were generally handled by S who seemed to be able to mediate between Q and the group.

Whether in response to invitations for assistance or in absence of any such invitations, the groups used various means to effect changes of behavior. In some instances a member of the group informed others about some aspect of the ward behavior of the patient, or informed them that the patient in question had stated that he was unwilling to cooperate in round-table sessions by recital of his history and problems. Comparisons were sometimes made of the behavior of two patients. Emphasis was placed, in comments concerning behavior, upon the importance of cooperation with and consideration of others. Delusions and their implications were frequently discussed critically. Expressions of hostility, as well as expressions of other moods and feelings, were encouraged. Criticism and application of pressure were used from time to time, but there was also frequent use of positive measures such as praise and other modes of supportive encouragement. In the men's group, in particular, praise was often used, especially when a patient had related his story in some detail and with apparent difficulty. At these times H and I would invariably compliment the patient on the story he had told and upon his desire to cooperate in his own treatment.

Consideration of the range and variability of activities of groups leads us to conclude that a great deal of social intelligence was exhibited, and that this intelligently directed activity enabled the groups to function effectively despite many factors tending toward disintegration of group activities. If this conclusion be accepted as valid, a further generalization can be made to the effect that it is not difficult to find psychotic patients who will assume responsible social roles, provided that appropriate opportunity for group activity is created and provided that there is suitable preparation for the group enterprise.

Major themes of sessions; cf. Appendix C. The major session themes seemed to be similar for both male and female groups with one notable exception. In the male group the subject of sex was brought up and discussed by only one table member, D, who was apparently extremely anxious concerning his own sexual preoccupations and concerning his confusions with regard to his sexual role. D did not seem to be genuinely interested in sexual problems of other patients. His efforts to turn discussion toward sexual topics were generally resisted by other members of the group. In the female group, on the other hand, an attempt to elicit the sexual experiences of each of the patients was made. This attempt was instigated by one patient, Q, but was taken up by the other table members.

Both groups dealt with the content of delusions, with childhood and educational experiences, and with the experiences and symptoms leading up to hospitalization, though concern with these topics was more evident in the female than in the male groups. In general, both

groups seemed concerned about the patient's relationships with mother and father, spouse, children, and siblings, with general marital problems, with recreational problems and social adjustment, with employment histories, adjustments to employers and fellow employees, and with vocational plans and possibilities for the future. In brief, the themes of round-table discussions extend over at least a great part of the topics which would be dealt with in individual interviews undertaken for therapeutic purposes.

Resistances and conflicts; cf. Appendix C. A fundamental conflict running through nearly all of the sessions was the conflict between group effort to obtain complete autobiographies and the effort of the autobiographers to avoid anxiety-laden areas. Resistance was exhibited by all patients. Expressions of resistance took various forms such as attempts to change the subject, manifestation of hostility to the questioner, attacks upon some other table member, attempts to turn questions upon another member. These resistances were in general more pronounced in the first few sessions, but they recurred after initial resistances had been broken down as new anxiety-laden areas were touched upon.

Efforts by group members to overcome resistances were persistent and often skillful. It was sometimes pointed out that "we are all in the same position," and at other times remarked encouragingly that, "it is very difficult to relate some things to others." Not infrequently the reluctant target was directly advised that "you don't want to talk about this, do you?" Some patients were informed that the *raison d'être* of group sessions was the relating and discussing of personal and significant experiences for the express purpose of improving the mental health of participants so that they might return to society. Another approach was the ignoring of a particular member of the group until he or she decided to take part. This ignoring was always tempered by occasional efforts to engage the individual in the group activity, but when these efforts failed the group turned to someone else and ignored the patient again, usually with such comments as "well he (she) can't even answer us, so let's not consider him any more right now," or "we can't waste any more time on him." Laughter was often resorted to, particularly when a patient persisted in relating delusional material. Occasionally a number of group members would become impatient and annoyed, expressing disgust with the continuing evasiveness and hostility of a particular member. This technique was most frequently used on B, and during the final sessions on D. This technique was not usually successful and seemed to be resorted to only when the group could find no other means of trying to "get to" a patient.

Patients S and I were particularly skillful in breaking down resistances, acting as kind, considerate, sympathetic, and understanding "mother-or-father figures," apparently anxious to prevent the other more aggressive questioners from attacking the resistant patient. Both S and I made good use of the hostility engendered toward others as a lever for establishment of positive relationship between themselves and target patients. This relationship was then utilized in encouraging target patients to discuss their problems with S and I. It is also interesting to note that the group was essentially fluid in its techniques, varying them in relation to attitudes of target patients. Variations in technique ranged from a permissive, nondirective approach to a demanding and highly directive approach. With the depressed and withdrawn patient tactics were usually gentle and encouraging, but with the aggressive, belligerent patient tactics were most frequently direct and forceful.

A second conflict which arose was between efforts of some patients to pressure the group into a "short-cut" action for release versus the effort of the group to arrive at decisions via extended discussion of the problems of the patient under discussion. Patients A, D, M, N, O, and R attempted to pressure the group into releasing them before they had related more than the barest outline of their histories and problems. Generally, the group resisted these efforts through ignoring the request to be voted to staff or through demanding more information before vote for release could be considered. In one instance the staff, having turned down

patients voted to staff, subsequently informed primees that these patients had used high pressure tactics to obtain a vote to staff before they were ready. In this instance primees were informed that manifestation of good judgment was a criterion for release, and that individuals who allowed themselves to be high pressured did not show sufficiently good judgment for successful social adjustment. After this episode the group utilized a method of demanding that each patient give the reason why he or she felt that the patient under question was or was not ready for release.

Competition for leadership is evident in several of the sessions. In the male group, D was particularly active in attempting to monopolize the group activity and, through nine sessions, was consistently countered by H and I, who managed to hold D in check while permitting him useful opportunity to satisfy his need for recognition. After H and I were discharged, A, B, and G attempted to restrain D, but were finally forced to ostracize him, by voting him from the table, in a drastic effort to control his behavior. In the female group, Q dominated the sessions, but was consistently restrained by S, who exercised a stabilizing and calming influence over Q and other members of the group. M and O attempted to break the influence of Q, but were apparently unable to make any noticeable change in the group structure. It is interesting to note that in the male sessions there were no leaders, per se, while in the female group Q and S definitely assumed leadership. Q was a dictatorial and aggressive leader, while S was more nearly a mediator.

Study of the content of sessions with reference to resistances and conflicts, and the methods used in dealing with them, yields further indications of remarkable potentialities for social manipulation on the part of psychotic patients. The intensity of competitive and other conflicts reflects increased anxiety which, as we have previously remarked, seems to be regularly produced by participation in round-table sessions, until such time as the individual acquires new modes of social behavior in which he feels confidence. The occurrence of evident resistances and the extensive expenditure of effort in attempts, which are often successful, to overcome resistances both seem to us to constitute evidence that the processes of round-table therapy are not psychologically superficial.

Roles and attitudes of participants; cf. Appendix D. In Appendix D are shown judgments, arrived at as described under "Methods of Analysis," concerning roles and attitudes of participants. Inactivity so complete as to yield no basis for judgment as to attitude, and absence of any active role, is indicated by a *dash* in the space in which a descriptive term would otherwise have been written. Inspection of the table reveals at once the relative activity of participants, and something of the nature of their activity.

Among the most active participants in the male group, patients G, H, and I played roles of responsibility—as autobiographers, as questioners, as supporters, as clarifiers, and as moderators. Their attitudes were primarily positive ones characterized by sympathy, friendliness, interest, cooperation, and sincerity. They carried most of the burden of encouraging others to talk. Patient D in the beginning sessions acted in a positive manner and was able to lead F, a seclusive, withdrawn individual, into group interaction. But D soon began showing extreme fluctuation both in his roles and attitudes, apparently because of heightened anxiety which may have involved something of a "homosexual panic." This fluctuation increased markedly when H and I were released, and began showing more negative character. Patient A also showed considerable variation in roles and attitudes,

complicated by a high degree of confusion. In general, however, as the sessions continued he began to assume more responsible roles and to show more positive attitudes in the performance of those roles. B, who was also an active participant, showed no ability to acquire or to maintain any responsible role and his general attitude can only be characterized as an egocentric one. Of the remaining male participants, C and F were unable to enter sufficiently into the group activity to establish any definite role or to demonstrate a characteristic attitude.

In the female group, Q and S played the most active roles, closely followed by M and O. Patient S consistently played a role of supporter, encourager, and clarifier, maintaining a highly positive attitude throughout. Patient Q was aggressive, belligerent, and impatient. Her role was primarily that of the "grand inquisitor" who attempted to browbeat the others into cooperation. Generally, Q was prevented from going too far in her dominance by S, who acted as mediator, and in one instance by P, who interceded for the others. Generally, the roles of M and O were complementary to the role of Q. In some instances they acquiesced to the superior force of Q and related their life histories without complaint. In other instances, however, they actively but unsuccessfully fought against the leadership she maintained.

Of the participants released from the hospital via recommendations of the round-table group (A, G, H, I, P, Q, S), all played active roles of essentially positive nature, with the exception of Q whose role was highly active but was aggressive. Conversely, of the nine patients who were not released from the hospital, five played roles characterized by evasiveness or inactivity. It is our opinion, as obtained from the data which we present and from the observations made during the group sessions, that as patients move toward increasing sociality and social effectiveness there is an increase in the positiveness of attitudes toward others and in assumption of responsibility for active participation in the group project. Consideration of prevailing atmospheres of sessions suggests, as previously remarked, that progress of the individual toward positiveness of attitudes is not merely a reflection of change in the general group milieu. The individual may move toward positiveness of attitudes in a group situation which is primarily negative (hostile) in character.

Study of roles and attitudes of participants, in relation to outcomes for individual patients and functioning of the group sessions, suggests certain considerations regarding selection of patients for participation in round-table psychotherapy. We believe that the major basis for selecting a prospective participant, with the expectation that he will respond favorably to round-table experience, should be judgment concerning his "intake" ability in contacts with other patients. This is to say that the patient is likely to respond favorably in direct proportion to manifestation of ability to enter into two-way contacts with others; such ability will, we believe, enable him, within the facilitating social context created by round-table procedure, to participate with some degree of activity in inquiry concerning the problems and behavior of another patient. It seems to us that ability to exhibit two-way contacts will carry with it an adequate probability that the role of the patient in group sessions will exhibit some positive aspects, and that growth in the direction of positive attitudes will occur in the course of round-table sessions. To state the matter negatively, we believe that the basis for *rejecting* a patient as a prospective participant should be a judgment that his crippling anxiety is so great as to prevent any genuine approach to understanding of others. We do not believe that, within the range of the presumably functional syndromes, conventional diagnoses are per se significant for selection of round-table participants. For example, paranoid symptoms do not contraindicate

round-table responsiveness if these symptoms are sufficiently fluid to permit two-way communication.

Our data do not provide convincing evidence that round-table participation is injurious to patients who fail to respond to round-table experience in any markedly positive manner. But we assume that no therapeutic effort which has any chance of producing beneficial results is without attendant risks of negative results. We believe, therefore, that only those patients should be selected for round-table participation who may be expected to respond favorably. We also believe that, since there exists no basis for selection which can guarantee success for all participants, nonresponding participants should be aided by individual therapy carried on concurrently with, and following, round-table participation. This procedure might enable the therapist to effect nontraumatic removal of the patient from the round-table group. But removal from the round-table situation should not be made on the basis of hasty judgment. It has been our experience that among patients who for several months do not appear to be responding some will abruptly, and dramatically, exhibit participatory activity which indicates that they have for an undetermined time been responding covertly and have benefited thereby.

Communicative structure of sessions. To indicate the communicative structure of the therapy sessions we devised the charts, which we have labeled "communigrams," shown below. The direction of questions, comments, and replies is shown by the direction of arrowheads along lines connecting positions of members of the group. Each arrowhead stands for a class interval of three communications, with a maximum of six arrowheads for any one individual in any session. Thus, any number of communications in excess of a total of 15 is shown by six arrowheads. Since the number of communications was obtained by a count of questions, replies, comments, and demands, the communigrams indicate extent of directed communications, but do not indicate autobiographic accounts or comments of spontaneous nature directed to the group as a whole.

The length of autobiographic accounts, when given in responses to query or demand, is likewise not indicated. We have, however, indicated by an asterisk, in each session, the member or members who presented a lengthy autobiographic account. These were usually participants who had been suggested, in priming sessions, as target patients.

Only patients C, F, and R so far resisted efforts to draw them into conversation as to fail to participate actively in at least some of the sessions. None of these three patients showed sufficient improvement to warrant consideration for release from the hospital.

It is instructive to note, by referring to judgments listed in Appendix C, that when the atmosphere was predominantly hostile (as in male sessions 10, 11, 12, 13, and female sessions 3, 4, 6, 8, 9, 10, 11, 12) more members seemed to be drawn into conversation than would otherwise be the case. This may reflect attempts of active members in a hostile situation to enlist recruits for plans and opinions. Another possibility is that "isolates" were disturbed by evidences of hostility and were impelled to enter into the group activity by a need to seek protection. It may be, also, that when the discussion was emotionally charged, some isolates felt freer than they might otherwise have felt to venture expressions of opinion

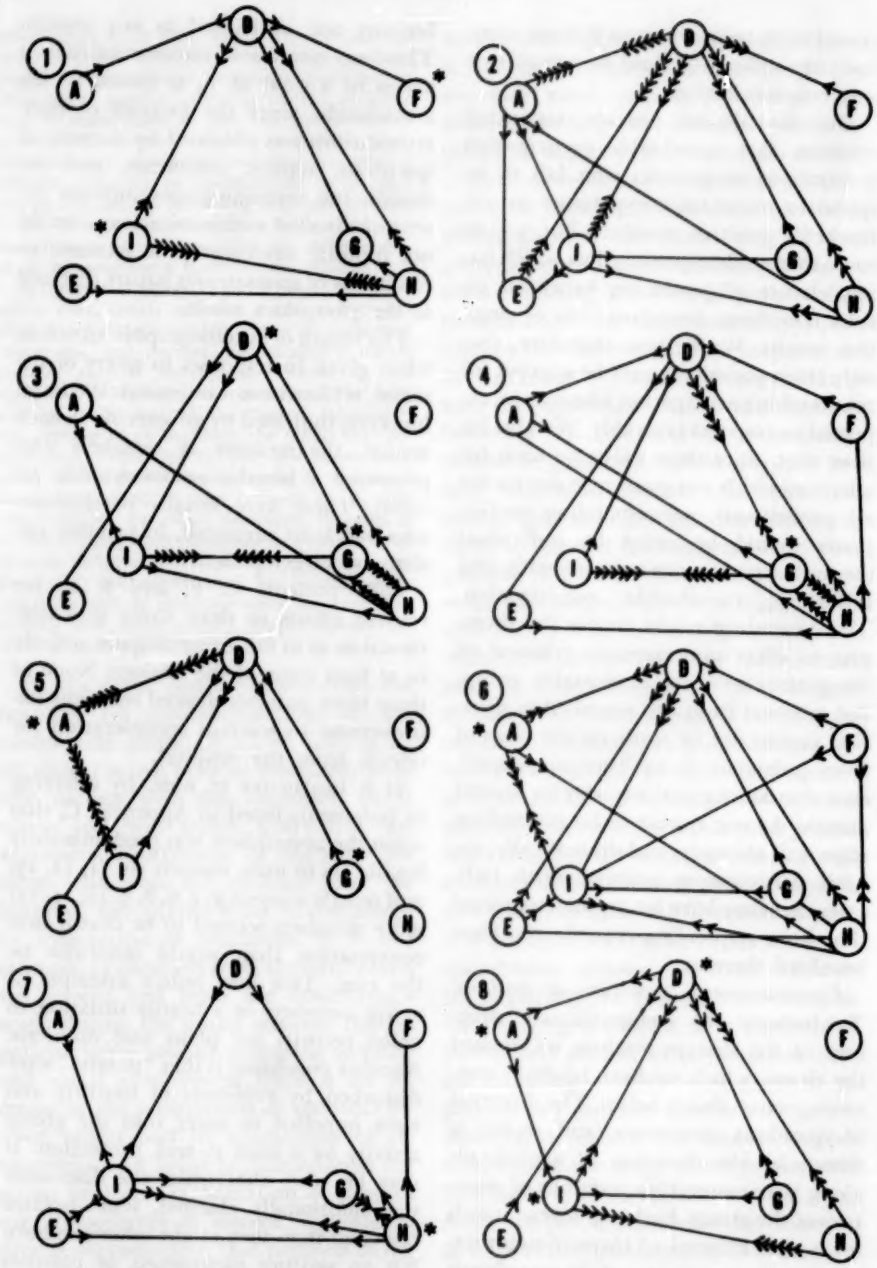

FIG. 1. **Communigrams of male sessions.** (Arrowheads indicate direction and number of questions and comments.)

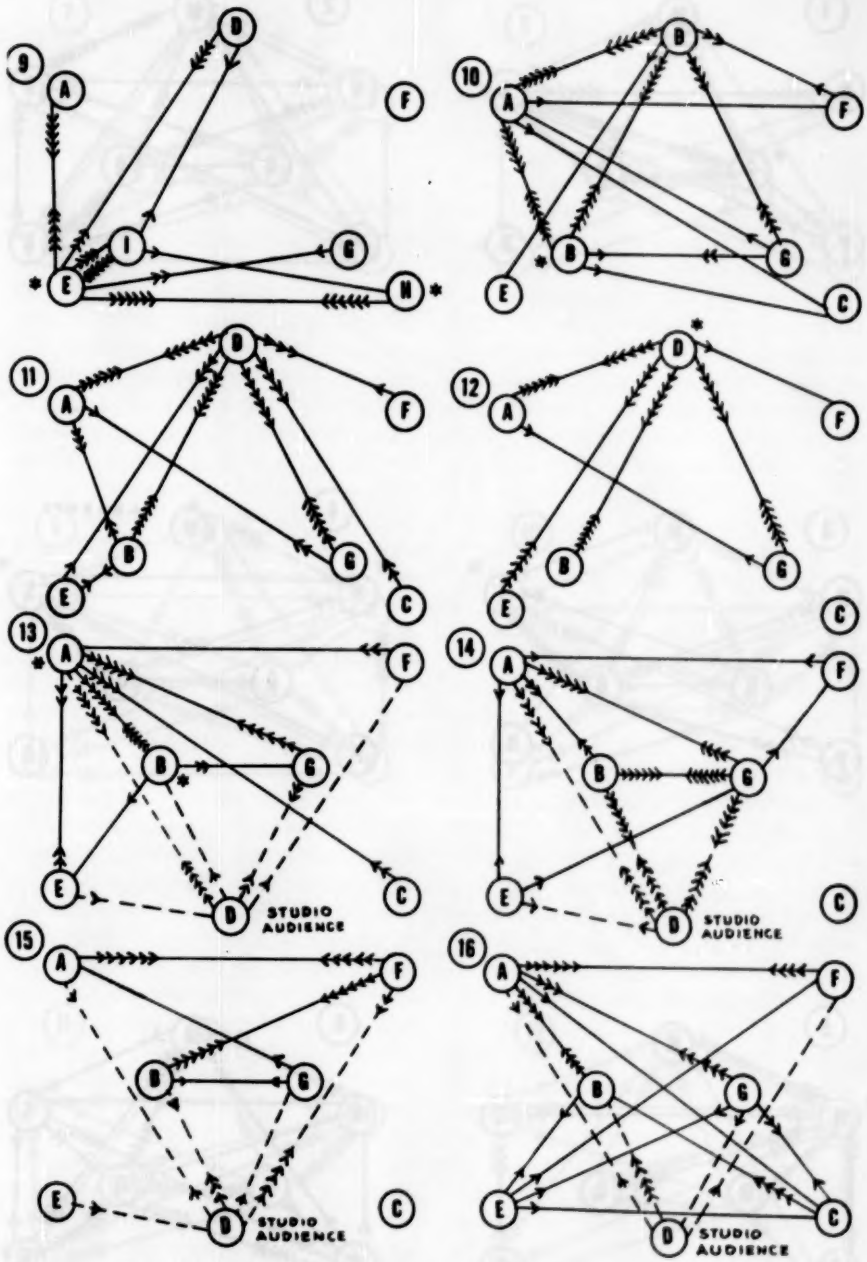

FIG. 1 (continued). Communigrams of male sessions. (Arrowheads indicate direction and number of questions and comments.)

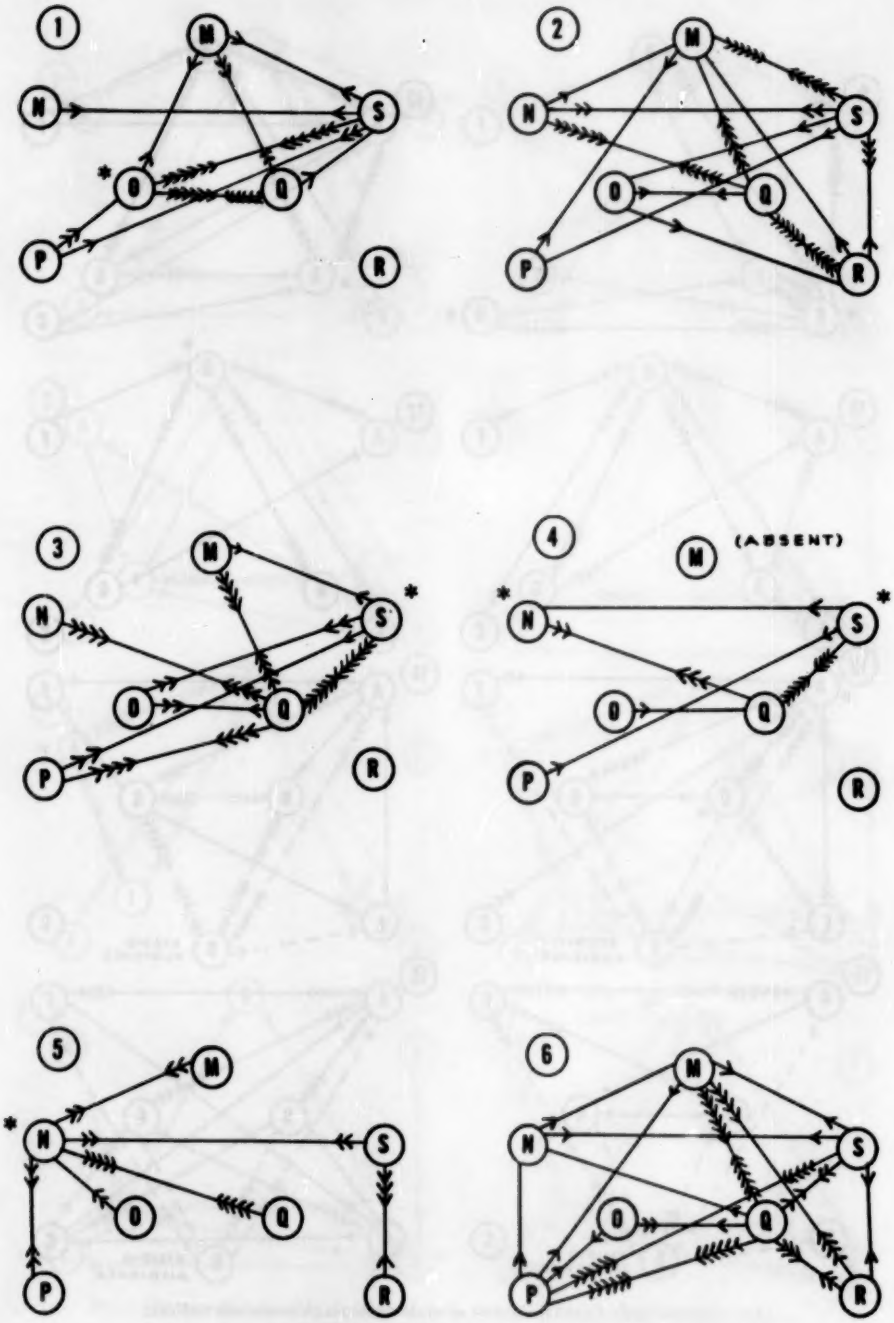

FIG. 2. Communigrams of female sessions. (Arrowheads indicate direction and number of questions and comments.)

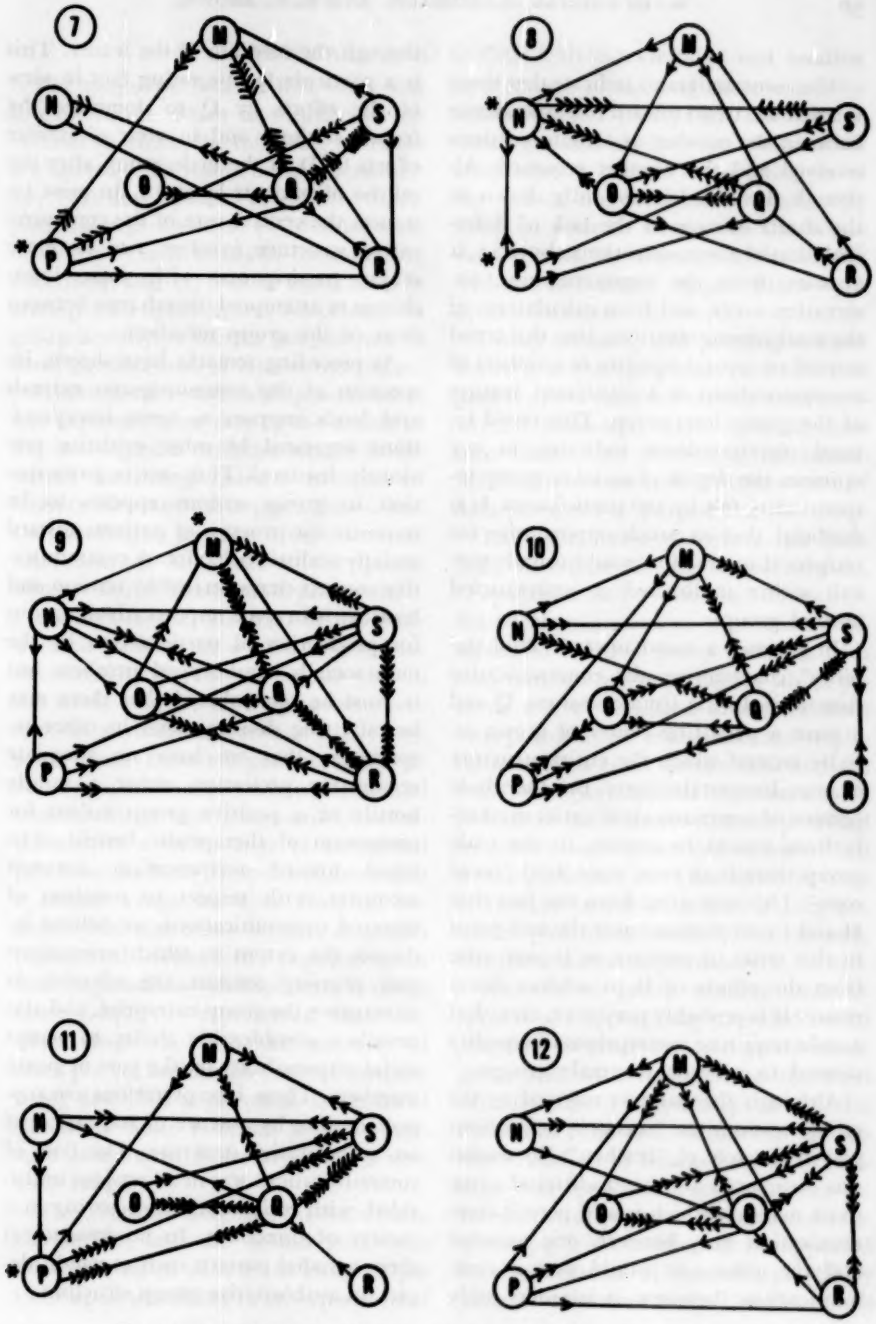

FIG. 2 (continued). Communigrams of female sessions. (Arrowheads indicate direction and number of questions and comments.)

without fear of attack.

The communigrams indicate that there is a definite trend toward correspondence between the number of communications received and the number returned. Although this trend is not fully shown in the charts because of the lack of differentiation of communications above 15, it appears, from the communigrams, observation notes, and from calculations of the total communications, that this trend toward reciprocal equality in numbers of communications is a significant feature of the group interaction. This trend toward correspondence indicates, in our opinion, the degree of social or group responsibility felt by the participants. It is doubtful that as much opportunity for reciprocal interaction would usually prevail within undirected or uninstructed normal groups.

In general, a trend toward "fluid stability" characterizes the communicative structures. In the female sessions, Q and S form a persisting center of group activity around which the entire structure of interchange takes form. But the whole pattern of communication varies markedly from session to session. In the male group there is an even more fluid "inner core." This may arise from the fact that H and I were released near the mid-point in this series of sessions, or it may arise from the efforts of D to achieve dominance. It is probably pertinent, also, that a code requiring assumptions of equality seemed to pervade the male group.

Although the patients referred to the group sessions as "classes," no patient played the role of "teacher." No session was structured in the traditional classroom manner, which would permit communication only between one member and the group, or would permit communications between nonleaders only through the medium of the leader. This is a particularly interesting fact in view of the efforts by Q to dominate the female sessions, and in view of similar efforts by D in the male group after the release of patients H and I. In most instances the central core of the communicative structure involves two or more major participants, with some interchange or attempted interchange between most of the group members.

As preceding remarks have shown, inspection of the communigrams extends and lends support to some interpretations suggested by other evidence previously discussed. Thus, active participation in group sessions appears to be requisite for progress of patients toward socially realistic behavior. A communicative context characterized by tension and hostility is in some respects advantageous for production of participation by the more socially handicapped members; but it must be remembered that there may be offsetting disadvantages in other respects, so that we have no adequate reason for preferring either a mildly hostile or a positive group milieu for promotion of therapeutic benefit. The trend toward reciprocation between members, with respect to numbers of directed communications, we believe indicates the extent to which orientation and priming sessions are effective in structuring the group enterprise, and also reveals a considerable ability to accept social responsibility on the part of group members. These interpretations are supported, also, by absence of indication of an authoritative structure. The flow of communications was in all sessions multisided, with reciprocations occurring in a variety of directions. In no instance is there a radial pattern such as would depict an authoritative group structure.

SUMMARY AND CONCLUSIONS

The major purpose of this study was to explore the extent to which, and the manner in which, the following processes are operative in round-table psychotherapy: (*a*) development of positive interpersonal relationships, (*b*) development of ability of individuals to communicate effectively, and (*c*) trial of social roles in attempts to participate adaptively in group activity. A further purpose was to study the functions of various component portions of the round-table procedure. It was expected, also, that in the course of the investigation evidence would be obtained indicating changes in level of anxiety of round-table participants, and contributing to progress toward accurate assessment of the general therapeutic effectiveness of round-table procedure.

Subjects for the first year of the study were 70 patients in a state hospital for the mentally ill. For the second year of the work, subjects were 63 patients resident in psychiatric wards of a city hospital. State Hospital patients were divided into male and female experimental and control groups. Diagnostic classifications cover a wide range of functional psychoses for State Hospital patients and a similar range for City Hospital patients, but with some organic diagnoses represented in the latter population. In both populations, schizophrenia is much more frequently represented than any other diagnosis, with the majority of cases placed under this general category being described as paranoid. Duration of illness for State Hospital patients averaged more than five years, with a very wide range.

The Wechsler-Bellevue, the Rorschach, the MAPS, and the Szondi tests were administered to each State Hospital patient upon admission to an experimental or a control group, and these tests were readministered (except for ten cases in which patients abruptly became unavailable) when a patient left a group or at the end of the first year of work. City Hospital patients were given the Wechsler-Bellevue, the Rorschach, the MAPS, and the Thematic Apperception tests upon admission.

Group sessions, and priming sessions between a therapist and an individual patient, were recorded on tape, and typewritten transcripts were made of these recordings. The transcripts of round-table sessions constitute a major source of data pertinent to purposes of the study.

The round-table procedure has been fully described in the second section, "Population and Procedure." It may be briefly characterized as a procedure designed to create a group situation with only patients participating, in which patients will be impelled to present their own problems for evaluation and exploration and to elicit similar presentations from other participants. The round-table procedure has directive features provided by orientation sessions and by individual priming sessions; it is a nondirective form of therapy in the sense that during any session patients are entirely on their own, i.e., the situation is permissive.

Analysis of group sessions with respect to the opportunity provided for all members to enter into the group enterprise, and with reference to the roles actually played by participants (cf. discussion of roles and attitudes in the section "Analysis of Group Sessions"), indicates that round-table sessions foster development of positive interpersonal relationships. This conclusion is supported by consideration of the roles played by patients who were judged to show such

improvements as to warrant release. The conclusion is given further support by significantly lower frequency, in terminal testing, of pathognomic and schizophrenic indices in responses of patients in experimental groups to the Rorschach and the MAPS tests, respectively. There is considerable suggestion in group activities, in themes dealt with in group sessions, and in the prevalence of efforts to bring all members into participation (as reflected in communigrams picturing flow of communications), that formation of positive relationships is fostered by the extent to which round-table procedure impels the participant to seek to understand others and to make himself understood. The extent to which the group sessions foster development of positive relationships is not, apparently, dependent upon the existence of a positive general attitudinal milieu or atmosphere in group sessions. It appears that at least some individuals may move toward positiveness of attitudes in a group situation which is to a considerable extent characterized by hostility and tension.

Increased ability to communicate with others through participation in round-table sessions is indicated by a trend toward increase in Wechsler-Bellevue scores and by reduction in schizophrenic indices in MAPS responses. Supporting evidence is found in the manner in which individuals were placed under pressure, often successfully, to re-examine their delusions and other maladaptive trends of thought. Examination of the communigrams, mentioned in the preceding paragraph, shows that there is a definite trend toward correspondence between the number of communications received and the number offered by the individual, that there is no authoritative communicative structure, and that all participants are at least sometimes drawn into participation. These characteristics of the round-table sessions, considered in relation to various features of content of discussions, seem to us to show that continuing pressure placed upon members to participate in the group enterprise is a major factor in round-table sessions tending to promote development of communicative ability.

The variety of techniques exhibited by many participants in their attempts to overcome resistances of fellow group members, and in attempts to control or resolve conflicts within the group, suggests that round-table sessions evoke trial of a variety of modes of social action on the part of at least some participants. This is indicated, also, by the changes which occur in the roles of some members. As suggested in the introductory section, this feature of round-table sessions may be in part an outcome of individuals being impelled to assume responsibility in a situation which is safe from censure by persons representing authority.

Trial of omission, singly, of priming sessions and of the playback of the record of the previous session, prior to the beginning of a new session, leads us to conclude that both these phases of procedure are important for adequate structuring of sessions. Our experience also leads us to conclude that the studio audience plays an important role in providing a supply of oriented replacements for the round-table and in providing a "public opinion" usefully imposing some checks upon round-table discussions. We found, also, that presence of a therapist during group sessions prevents effective round-table procedure. Patients tend to seek to depend upon the therapist and to be guided

by him, so that advantages accruing from assumption of participant responsibility are lost. We found, also, that offering the incentive, in orientation sessions, of gaining release through participation in round-table sessions is at least highly effective as a part of advices designed to structure ensuing group sessions.

We interpret some features of test results and of the content of group sessions to mean that at least many round-table members experience an increase in level of anxiety during early sessions in which they participate, and that some members work through this to a reduced level of anxiety while others do not. Thus among 16 patients who were participants in sessions chosen for detailed analysis, none of the three whose scores on the Wechsler-Bellevue showed a decrease were among those who showed sufficient improvement in behavior to gain release from the hospital. Some qualitative observations suggest that the lowered scores reflect increased anxiety. Also, the content of sessions includes some indications that resistances to questioning are most pronounced on the part of most patients in early sessions, but that in some instances these resistances are not broken down in later sessions.

Indications concerning success or failure of round-table participants to progress toward effective socialization of behavior, and concerning the contributions of participants to success of the group sessions, suggest that care should be exercised in selecting prospective participants and also in retaining apparently nonresponding patients. We believe that patients should be admitted only if they exhibit some ability to receive communications concerning the problems of others. Conventional classificatory diagnoses, within the range of presumably functional syndromes, do not seem to us to be usable as bases for selection of round-table participants. We suggest, also, that nonresponding round-table participants should be given individual therapeutic aid, and that continuance or noncontinuance in the round-table group should be determined through such individual assistance.

Results from pre- and posttesting, when compared for experimental and control groups, provide evidence that in the main, or for the average patient, participation in round-table sessions is therapeutically beneficial. In general, test results indicate that in consequence of round-table participation there is an increase in manifested general ability, in ability to perceive likenesses and differences, in openness to environmental stimulation, and in other types of test responses having normal character. A favorable estimate of the value of round-table therapy is also supported by preceding conclusions concerning probable development of abilities to form positive interpersonal relationships, to communicate, and to utilize a variety of social skills. All of these directions of evidence seem to be in harmony with comparisons, shown in Table 1, of experimental and control groups with respect to clinical status at the end of their participation in the study. Sixty-four per cent of the members in experimental groups were rated as improved (40 per cent being discharged from the hospital) as compared with 12½ per cent rated as improved (all of these being discharged from the hospital) from the membership of control groups.

APPENDIX A

Sketches of Patients Participating in Groups Selected for Intensive Study

Male Patients

A: Single, age 20, one year of high school. Family history states he had considerable difficulty in school and later had difficulty in staying on a job. He was moody and quarrelsome when a youngster, seemed unusually jealous of his brother. Onset of illness in June, 1950. Patient seemed confused, very irritable, and destructive at times, and delusional. Admitted to State Hospital No. 2 in 1950 after four months treatment in a private psychiatric institution. Diagnosis, Schizophrenia, mixed type. Discharged from hospital.

B: Single, age 34, two years of high school. No adequate family history. Onset of illness in 1935 when patient fainted while at school. He was kept out of school after that and became depressed and worried, very irritable, delusional, and often laughed without observable cause. Resident in State Hospital No. 2 for periods of about two years beginning in 1936, 1939, and 1942. Last admission in 1950. Diagnosis, Schizophrenia, paranoid type. Transferred to a back ward.

C: Single, age 21, high school education. Reported to have been industrious and to have done exceptionally well at school. Hunted frequently; for several months before commitment became so careless with guns that family was forced to put them away. Patient then fashioned guns out of wood and tried to discharge .22 shells with a spring arrangement. Onset of illness in June, 1947, when he became confused, dizzy, complained of pains in back of neck. Last admission to State Hospital No. 2 in 1948, after previous hospitalizations totaling nine months in several private psychiatric hospitals and in State Hospital No. 2. Diagnosis, Schizophrenia, paranoid type. Transferred to a back ward.

D: Single, age 17, two years of high school. Family history gives no indication of difficulty before 14 years of age. Family reports he was a good student in school, got along well with others. After about 14, he is said to have been nervous, restless, and moody, and was committed to a state training school at the age of 16, following automobile theft. Reports from the training school indicate the first noticeable symptoms of mental illness were apparent confusion and a state of being dazed. Admitted to State Hospital No. 2 in 1950. Patient was stuporous and untidy. Diagnosis, Schizophrenia, catatonic type. Transferred to a violent ward.

E: Single, age 23, high school education. Family history reports this patient was always quiet and shy. His mother was committed to a state hospital when he was 11 years old, and relationship between patient and woman who cared for him was "very unhappy." Onset of illness in February, 1950, when patient reported people were attempting to put t.b. germs into him, and he became convinced he had t.b. Felt that an organization was after him and had wired his room. Admitted to State Hospital No. 2 in 1950, after seven months treatment in a city hospital. Diagnosis, Schizophrenia, paranoid type. Improved: recommended for discharge but requested permission to remain in hospital.

F. Divorced, age 47, high school education. No adequate family history. Date of onset of illness, August, 1934. Admitted to a state hospital in 1934. Paroled in 1949. Admitted to State Hospital No. 2 in 1950. Patient refused to work while on parole. In the ward, usually sat quietly with eyes closed all day without speaking to others. Some delusions of persecution. Diagnosis, Schizophrenia, catatonic type. Transferred to a back ward.

G: Married, age 43, fifth grade education. No adequate family history. Onset of illness, May, 1951, when he began having auditory hallucinations of mother's voice calling him. Became confused, cried, and at times was paralyzed and unable to move. Feared wife was attempting to poison him. Admitted to State Hospital No. 2 in May, 1951. Diagnosis, Schizophrenia, undetermined type. Discharged from hospital.

H: Married, age 38, ninth grade education. No adequate family history. Onset of illness in September, 1945. Patient became restless, talked little, had evident auditory hallucinations. Slept and ate poorly. Admitted to State Hospital No. 2 in 1946, after seven months previous hospitalization. Diagnosis, Schizophrenia, mixed type. Discharged from hospital.

I: Married, age 28, one year of high school. No adequate family history. Onset of illness in adolescence. Patient served in National Guard for several months, was discharged for instability. Arrested in 1938 for passing a bad check. Admitted to State Hospital No. 2 in 1939, after a total of seven months previous treatment in a private hospital and a city hospital. Diagnosis, Psychopathic Personality with amoral trends. Discharged from hospital.

Female Patients

M: Single, age 29, high school education. Patient's mother and father were separated during the greater part of her life. Very shy, timid, and self-conscious as a child. Patient was neat, cleanly, and industrious before onset of illness. Hospitalized in 1947 following death of mother. Illness characterized by delusions of persecution and of pregnancy. Violent at times. No previous hospitalization. Diagnosis, Schizophrenia, paranoid type. Transferred to a back ward.

N: Single, age 34, college education. Patient was adopted at the age of nine days and had always seemed "resentful" toward foster parents. Foster mother reports that she was quiet, unsocial, unaffectionate, and given to daydreaming. Onset of illness in December, 1949, in Europe. Patient exhibited delusions of persecution with auditory and visual hallucinations. Previous hospitalization of two months in a city hospital. Diagnosis, Schizophrenia, paranoid type. Transferred to a back ward.

O: Divorced, age 38, eighth grade education. Patient reported to have been nervous, quiet, and shy as a child. Patient is the mother of an illegitimate child, born in 1936, which was placed for adoption at birth; she has two legitimate children. Onset of illness in 1947. Patient exhibited delusions of persecution in which she felt the neighbors were turning an X-ray machine on her. Said to have kept windows and doors locked and windows nailed shut. Auditory hallucinations. Admitted to State Hospital No. 2 in 1949, following a total of two years previous hospitalization. Diagnosis, Paranoid Condition. Transferred to back ward.

P: Single, age 47, high school education. Patient reported to have been always considerate and easy to get along with. Onset of illness in 1949 when patient began expressing fears, threatening suicide, and indicating she felt someone was attempting to poison her to "get her in trouble." Admitted to State Hospital No. 2 in 1949, after three months hospitalization in a private psychiatric hospital and in a city hospital. Diagnosis, Paranoid Condition. Discharged from hospital.

Q: Divorced, age 23, eighth grade education. No family history available. Patient states that father died when she was two years old, leaving no income for the family of nine. After moving around for several years, the family was split up, with most of the children going to orphanages. Onset of illness in December, 1950, upon the birth of a second child. Patient was confused and disoriented. Hospitalized for seven months in a city institution. Admitted to State Hospital No. 2 in 1951. Diagnosis, Schizophrenia, undetermined type, with possibility of early organic brain damage. Discharged from hospital.

R: Single, age 39, one year of college. No adequate family history. Onset of illness in May, 1949. Patient cried easily, became delusional, and felt she had committed an unforgivable sin. Auditory hallucinations, very confused and anxious. Admitted to State Hospital No. 2 in 1949, with no previous hospitalization. Diagnosis, Involutional Melancholia. Transferred to back ward.

S: Widowed, age 36, high school education. No adequate family history. Husband committed suicide after patient was hospitalized. Illness characterized by delusions, fear of her neighbors, and a belief that someone had kidnapped her youngest child. Admitted to State Hospital No. 2 in May, 1951, with record of seven months treatment in another state hospital. Diagnosis, Reactive Depression. Discharged from hospital.

APPENDIX B

Appendix B is deposited with the American Documentation Institute. The Appendix consists of two tables which show, in detail, for 15 patients in round-table groups selected for intensive study, scores obtained from administration of the Wechsler-Bellevue and the Rorschach tests prior to the beginning of round-table sessions and at the end of the year of round-table work or at the termination of participation of the individual in the round-table sessions. Subtest scores and total scores are shown for the Wechsler-Bellevue. Scores are shown for 25 Rorschach scoring categories.

To obtain Appendix B, order Document No. 4348 from the ADI Auxiliary Publications Project, Photoduplication Service, Library of Congress, Washington 25, D.C., remitting in advance $1.25 for microfilm or $1.25 for photocopies. Make checks payable to Chief, Photoduplication Service, Library of Congress.

APPENDIX C

Summaries and Ratings of Sessions Selected for Intensive Study

Male Sessions

Session 1: H asks I if he wishes to tell his story. I says he is in the hospital because he and his wife discussed his condition and decided that he was in need of treatment. H asks about family relationships and work history, then questions I about frustrations and temper. This leads to a discussion of work experiences, and previous hospitalization, which I says was at the suggestion of his mother. I discusses his feelings about this hospitalization. There follows discussion of work history, family relationships, and general marital adjustment. This is followed by discussion of I's children, his parents, and a description of his symptoms. I then requests suggestions for improving his behavior. Discussion then switches to the irrational behavior of D. A general discussion and criticism of D's behavior follows. I then attempts to draw E and G into the discussion. *Atmosphere:* friendly and sympathetic. *Major Activity:* listening to and commenting upon I's story. *Major Theme(s):* I's family relationships and occupational history.

Session 2: Session begins with a discussion of what to talk about and to whom to talk. D is questioned about his prehospital experiences and ward behavior. D evades discussion and lobbies for parole. D is again questioned about behavior, but evades questions and continues lobbying. Patient A joins D, while others remain disinterested. D suggests a "deal" so that all can go home. Suggestion is ignored. D continues pressure and attempts a "steam-roller." I objects and a discussion between I and D, concerning D's behavior, ensues. D attempts to avoid I's questions but is unable to do so and finally begins to talk, but slips back around to the vote. There is continued effort by several participants to get D to examine his behavior. D is noncommittal with regard to various biographic details concerning which he is questioned. Group gives in to D's pressure and approves his request for parole. D imitates radio announcer going off the air. *Atmosphere:* resistive. *Major Activity:* resisting (unsuccessfully) D's pressuring to be voted to staff; attempts by A, H, and I to explore D's problems. *Major Theme(s):* D's family relationships, his history of theft of automobiles, his erratic behavior on ward, advice concerning his possible parole for Thanksgiving.

Session 3: H suggests that G tell his story. D interrupts and is silenced by H. H questions G about the hospital, and about his home life and work history. I tells D to "shut up and listen, it might do you some good." H and I attempt to get G to "cry on their shoulders." Questioning shifts to G's relationships with his wife. There is a general discussion of the apparent lack of cooperation and consideration between the two. Several instances of G's wife's acting contrary to his wishes are given by G, and G's attack on his wife is mentioned by several participants. Patient A attempts to discuss farming methods and is informed that this is immaterial. The discussion of family relationships—with wife, children, and relatives—continues, with H and I questioning G, giving suggestions and in general supporting him. During the session G attempts to answer all questions but does so with yes and no, until H and I press him by asking "how do you feel about it." Discussion is interrupted by the signal. *Atmosphere:* sympathetic and helpful. *Major Activity:* discussion of story elicited from G. *Major Theme(s):* G's family relationships and farming experience.

Session 4: Session begins with I starting to question G further about his family relationships —what family members did together, their recreational activities, things shared in common, etc. Discussion reveals that G has little in common with his wife or children. Patient A inquires if G has ever felt like committing suicide. G denies this. Further questioning reveals that G is unable to remember many incidents. His memory defects show up when discussion centers around his wife's relationship with another man and aggressive behavior by G. There is continued pressuring on G for expression of his feelings about his wife and family and his beliefs as to how they think and feel about him. D asks about G's hallucinatory experience; D, H, and I point out the improbability of the "vision" which G admits having had of his wife visiting the hospital grounds (G had reported this vision on the ward). G finally concurs with this viewpoint, saying, "I could have wanted to see her and just thought I did." Final moments are spent in attempting to draw F into discussion. *Atmosphere:* friendly and helpful. *Major Activity:* questioning G concerning his experiences and family relationships. *Major Theme(s):* G's relationships with his family and his experiences before commitment.

Session 5: The session begins with unsuccessful pressuring for vote to staff for I, G, and D. D suggests that A tell his story. Patient A relates childhood and school experiences, speaks delusionally, and is challenged by several members of the group. Patient A becomes defensive and evasive, but continues the discussion. I gives A support and encouragement. Patient A admits irrational behavior, but for a time denies hostility. He finally admits jealousy toward his brother. There is continued discussion of A's family relationships—attitudes of parents, sibling,

etc. Strong hostility and ambivalence are revealed by A. D brings up the matter of A's jealousy toward his brother which A now denies. After continued discussion, A is voted to staff. Final moments are spent in debating who the new table members should be, assuming that vacancies will shortly occur. It is decided that B and C will join the round-table group when vacancies permit. *Atmosphere:* friendly and helpful. *Major Activity:* discussing and exploring A's story. *Major Theme(s):* A's prehospital experiences, relationships with his brother and other members of his family, and A's interpretation of causes of his difficulties.

Session 6: D starts session with a canvass of table members on their previous vote on A, asking that they state reasons for their votes. This canvass continues with requests for vote on I, G, and D. They are voted to staff. Each of the members to go to staff is discussed—the behavior which caused difficulty is brought out, suggestions for improving social adjustment are made, and questions about plans and general behavior when released are asked. Patient A requests ground parole, and this brings up discussion about the power of the "round-table members." D attempts to get F to tell his story. F refuses, suggesting that they use the remaining time usefully. D informs F that unless he is cooperative and relates his story he will not be able to get out. H evidences a desire to discuss his problems and begins relating some of his history. *Atmosphere:* cooperative and helpful. *Major Activity:* voting members to staff. *Major Theme(s):* Discussion of members recommended for release, with statements of reasons for votes.

Session 7: H continues relating his story, without interruption from table members. D begins questioning H about his family. H replies by discussing financial difficulties. D suggests voting H to staff. A studio audience member questions H about his work. General discussion about H's work history begins, but is interrupted by questions about his illness. I prevents H from answering these questions. The studio audience member questions H about his children and about their feelings with regard to marital difficulties of their parents. H avoids answering, and asks E if he has any questions. The studio audience member asks H what bothers him most. H replies "being locked up." A second discussion about work follows, with occasional comments about H's home and mother. *Atmosphere:* permissive. *Major Activity:* discussion of H's story, with questioning concerning his experiences and family relationships. *Major Theme(s):* H's story and experiences before coming to the hospital, and reasons for his commitment.

Session 8: H asks if table members wish to discuss his problems further. D suggests a vote to staff. After a short discussion a favorable vote is taken. H asks I what happened at the previous staff. I states that he was neither approved nor rejected, then launches into a discussion of his "criminal" career and reveals his earlier antisocial attitudes and feelings. Questions are asked about staff estimates of judgment shown in round-table actions in deciding whether a patient is ready for release. I says that his votes for A and D counted against him. H questions I about military service and about reasons for his discharge, which I answers without hesitation. Discussion of H's school experiences, reasons for quitting school, and future work plans follow. Patient A asks if they want to hear what happened to him at his meeting with the staff. He relates how his story of the "little bean" (a hallucinatory experience) tripped him up. He becomes quite confused in relating this, talks about sex, and finally lapses into illogical and incoherent speech. H asks D why he didn't pass. D begins to relate his reasons, then suddenly begins relating how he felt when he first came to the hospital, how "voices" spoke to him and what they said. During this speech the words "flooded out." A studio audience member interrupts with a completely irrelevant question. Patient A expresses a desire to hear from someone else. D informs him that he isn't through. G and H encourage D to continue. D shifts to experiences in a reformatory and then to home life, with some discussion of the various family members. *Atmosphere:* competitive. *Major Activity:* voting H to staff; elicitation of reports from members who have been before the staff, and further accounts by several members of experiences before and during hospitalization. *Major Theme(s):* experiences of A, D, and I at staff conference.

Session 9: Patient A says he isn't going to talk. D begins questioning E about his family and cousins, why and how he happened to come to the hospital. E answers questions but volunteers nothing. Discussion of E's delusions follows with E unwilling to discuss them. E is encouraged to discuss his feelings. I asks about E's dreams, but E does not respond. Questions about work history are answered monosyllabically. E is asked about going out, but replies that he isn't interested. I questions E about his childhood. Questioned again about going home, E says he would just sit if he went home. H suggests that he doesn't do that in the ward. Questions are asked about why E would be inactive if at home. Questions are asked about the importance of E's stuttering, and suggestions for improving his social life are given. The problem of having been a mental patient comes up. Several patients express their views and say that this is not a "real handicap." E states that he

is happy in the hospital—that he has friends and can do some work. Discussion comes back to stuttering and effort is made to reassure E. A discussion of the function of talking about problems follows. One patient tells about reading an article which says recovery is up to the patient. Discussion continued to the end of the session about the aims and purposes of the group and the need for cooperation. *Atmosphere:* permissive. *Major Activity:* attempts to get an autobiography from E, and questioning E concerning his attitudes and behavior. *Major Theme(s):* the history and attitudes of E.

Session 10: (I and H have been released; B and C are now table members.) G tells A to continue his story. D pressures group for a vote on various members. E is asked to state his opinion about himself, but refuses; he is nevertheless voted to staff. There is discussion about who should tell his story. Patient A is told that he can't talk. B wants to talk and is told also he cannot; when D starts to talk, B interrupts and a violent verbal battle ensues. B finally begins his story, but is constantly attacked by D. Further argument, with all table members participating, starts. Patient A calls for order and B continues his story about school experiences immediately prior to commitment. D continues throwing jibes at B, who counters by saying that his mother and father wouldn't let him solve his problems. D asks B if he is well. B says that he is. At this point D brings up B's delusional and hallucinatory behavior, which B admits but attempts to justify as normal. B continues his story, and D quietly mixes him up and makes a fool of him. Group members decide that they aren't getting anywhere. B continues, and A attempts to make a parallel of his own and B's experiences. Discussion follows concerning the character of mental illness with emphasis on the fact that mental illness develops over a long period of time. Patient A begins to comment that B is part of his delusional world. B denies this. Patients A and D discuss B's story critically and show disgust with B. Patients A and D then decide that the meeting was a waste of time. D says the cause was "lack of cooperation." G says he tried to get A to talk. Patient A says D is not "running things." B interrupts to say, "I decided what to do but you guys just don't understand." *Atmosphere:* hostile. *Major Activity:* obtaining agreement on who is to talk, and questioning B concerning his story. *Major Theme(s):* B's story.

Session 11: D begins the session by discussing B critically. There is a rapid shift in subject. D continues berating B, then starts relating more of his own history in a grandiose manner. B laughs and D calls him stupid; B says to D, "You think you're so good but you can't even give a girl a job." D says he could too, and then asks what kind of "woman's vocation do you mean?" D says that B is "crazy." B says that D is just jealous of him. D proposes a vote on B and then pressures the group, successfully, to turn him down. Patient A says he voted no on B because "I don't know whether you were a member of scout troop 413 or just a visitor" (a return to a delusion previously expressed by A). General confusion follows, with everyone talking at once. B attempts to get on the good side of D by saying that he "sends messages to D's folks and gets them to come and visit." The entire group attacks this statement, but B continues defending his idea. G attempts to get A to tell his story. The argument between B and D continues, and, in exasperation, B leaves the table but is forced to come back by D who threatens that one member of the studio audience will beat B. B returns to the table and the discussion continues, with D subtly encouraging a studio audience member to attack B. B says that he and therapist had discussed D, but when pressed on this admits that his statement is false. Both B and D continue trying to enlist others on their side. B accuses D of being full of hatred. D threatens B with physical violence. Other table members call him down. D begins talking about his high school sex interests. He begins asking other members if they masturbated. B and G deny this. Other table members accuse them of lying. D says masturbation is universal. This is denied by B. The session concludes with D talking grandiosely about his jobs. *Atmosphere:* hostile. *Major Activity:* listening to hostile interchanges between B and D, unsuccessfully attempting to vote on B, listening to further history from D. *Major Theme(s):* D's attack upon B and further presentation by D of his preoccupations and problems.

Session 12: D begins talking about "the story of my sexual desires," enumerating his library of sexology. He brings out his preoccupation with and also identification with the female sex role. The conversation shifts to other topics, but comes back to sexual desires. D states that he "enjoys talking to the psychologists and the superintendent about his infected uterus," then begins talking about his mother and her cooking. General conversation follows about cooking, and then discussion shifts back to D and his sex interest. G persistently objects to talk about sex, but D ignores this. Discussion of D's reformatory experiences follows, with D emphasizing his excretory difficulties. D is questioned about heterosexual sex experiences which he at first denies and then later admits. The session is concluded with a rambling discussion by D of his experiences in the reformatory and of his grandiose ideas about work. *Atmosphere:*

hostile. *Major Activity:* listening to D's account of his experiences and preoccupations. *Major Theme(s):* D's sexual desires and his experiences in the reformatory.

Session 13: An unsuccessful attempt is made to vote B to staff. When members are asked to express their opinion, D tries to talk. G suggests voting D away from the table. D becomes excited and insists they can't do this to him and tries to solicit votes for himself. He is voted away from the table, but refuses to go and insists that the therapist come to get him. G insists that D leave the table. D leaves the table, saying "I'll go clear to the back of the room." After further commotion, the group settles down and B tries to get voted to staff, but the group does not cooperate with him. Patient A starts telling of his experiences and discusses a homosexual experience with a relative. He then lapses into delusional material. Finally A again suggests that the group vote him to staff, and gets an unfavorable vote. Then D votes himself back to the table, but this action is ignored. D then suggests that G be voted away from the table. This is also ignored. *Atmosphere:* hostile in beginning, becoming less hostile toward the end. *Major Activity:* voting D from the table (to studio audience), and listening to A's story. *Major Theme(s):* consideration (negative) of efforts by A and B to obtain vote to staff, and A's story of difficulties of adjustment at school and elsewhere.

Session 14: D (in studio audience) starts off meeting by saying he's going to talk "every damned minute." After some general discussion G beings telling his story, relating his marital difficulties and speaking of his wife's alleged infidelity. He tells others "not to bother with women." D agrees, and says he has had difficulties with them. G becomes sad, and D sympathizes with and encourages him. General discussion of marital problems follows, with numerous suggested solutions. The battle between B and D continues. G indicates that he and his wife can't make it, so he'll go somewhere else. Patient A suggests a vote for staff for himself, but then apologizes for interrupting and suggests that G continue his story. There is further discussion and questioning about G's story of his wife's infidelity. Discussion goes on to questions about the children of G. G says he doesn't have much to do with his children, saying that his wife has turned them against him. B attempts to start talking about himself but is stopped. D attempts to get back to the table and threatens B. G is voted to staff. D wants the group to remove his cuffs, but this is refused. The meeting concludes with vague, disorganized conversation and with B's effort to tell his story again. *Atmosphere:* sympathetic and interested. *Major Activity:* listening to and questioning G concerning his marital problems. *Major Theme(s):* G's marital problems and difficulties.

Session 15: Patient A begins the session by describing the group procedure to new studio audience members. After this explanation, F is asked to tell his story. F is not anxious to talk, but members of the group compliment him, sympathize with him, and finally succeed in getting him started. F relates that he has been in a state hospital for 15 years, and that he believes that attendants do not like the patients to talk. Various group members explain that this isn't true now. Attempts are made to question F about his life, but he says "this questioning is irrelevant." After some discussion about family and work, F says he's through. B continues questioning, and F answers protestingly. After long discussion F again comments about how different this hospital is—that he isn't used to discussions. He is encouraged, and it is urged that it is all right to talk. F is advised that the expression of feelings, attitudes, and ideas is important. F vacillates between being resistant to talking and telling just a few personal things about himself. *Atmosphere:* concerned and interested. *Major Activity:* endeavor to get F to talk. *Major Theme(s):* F's occupations and hospital experiences.

Session 16: D attempts to get the group to talk to C. The discussion switches to the question as to how a studio audience member got a black eye, and this discussion ends with assurance from various group members that full inquiry will be made. G says he has been passed by the staff for release and says, "There ain't nobody in this therapy room that carried the load I have and lost it." G continues by relating to the group how differently he feels since he faced his problems. B attempts to talk to F, but F says he's through. The group continues attempts to get F to talk. F resists and the group continues to urge him, encouraging, sympathizing, and flattering him, succeeding finally in getting some responses to questions about clothes. F is reminded that he can't go home if he doesn't give the group sufficient information about himself. Attempts to find further topics about which F will talk are unsuccessful. The group turns to questioning C. Patient A hits B because he won't remain quiet. Other members of the group reprimand A. C talks about school and about his work, in short sentences. *Atmosphere:* generally supportive and friendly. *Major Activity:* attempts to persuade F to talk. *Major Theme(s):* history and problems of F and of C.

Female Sessions

Session 1: S suggests ways to improve ward conditions. M, N, and S discuss this. O says that

group meetings have to do with "solving our problems and relieving our minds." S suggests that O tell her story. O invites criticism of her behavior; is reassured; tells about her delusions. Then she discusses her children, who are in an orphanage. S questions O about the children and the orphanage. Q questions O about various hallucinations, which are denied by O. Q questions O about her sexual relations which O discusses frankly. M asks O if her beliefs (delusions) about X-ray and thought machines are still held. O says they are not. General discussion follows about what the patient would do with her children, how she could support them, etc., if she were released. M, Q, and S point out that the children are cared for better than O could care for them. O denies this, and insists on moral and sentimental grounds that "mothers and children should be together." O denies "sinful behavior." O introduces religious topics and is taken to task by Q. S supports O's right to discuss religious beliefs, but Q indignantly continues her criticism of O. Q asks M to tell her story. M begins reluctantly, and relates some events, replying evasively to questions. *Atmosphere:* friendly but critical. *Major Activity:* questioning and challenging O. *Major Theme(s):* O's history of illness and desires for her children.

Session 2: Q gives commands and warnings to get the session underway. N and R ask if they should present their stories. N and Q question R. R expresses a desire to talk in order to get release, but is reluctant to give a detailed history. Table members continue questioning R in an attempt to fill in gaps in her story. Q and S ask questions about R's childhood. A studio audience member begins heckling. Q and the studio audience member get involved in a bitter discussion over the authority and rights of round-table and studio audience members. Q continues pressuring R to talk more freely. O defends R. M questions R about her ward behavior, and Q questions her about sexual experiences. R continues to answer evasively. Q continues pressuring R while N and O attempt to ease the pressure. Q suddenly switches her questions to M, who answers by discussing high school experiences. Q questions M about sexual experiences. These questions are evaded by M, with the assistance of N and a studio audience member. S and M discuss M's work history. P and S question M about her illness. M says she had amnesia following shock treatment, and discusses various psychosomatic ailments. Q questions M about her social activities. O and S support M, and give her suggestions for improving social life. Q questions N about her illness, the visits of her relatives, and her refusal to wear "ward clothing." Q turns questioning to N's sexual experiences. N is evasive in answering all questions. *Atmosphere:* impatient and critical. *Major Activity:* attempts to elicit full autobiographic stories. *Major Theme(s):* autobiographies of M, N, and R.

Session 3: The group begins questioning Q about her "breakdown" and her relationship with her husband. Discussion continues concerning Q's financial and marital situation. Q is slightly evasive. S asks Q about symptoms, and about her reasons for working. Q continues evading. The group attempts to discuss reasons for Q's divorce, but Q will not give sufficient information. She denies having any extramarital affairs. Questioning switches to school experiences and to Q's relationships with her parents. S questions Q about recreational activities of her and her husband. N asks Q about her plans after release. Attempts to discuss Q's divorce are continued. P asks Q if she had "a lapse of memory." Q agrees that she did, and states that her breakdown occurred after divorce. S finally states that Q apparently isn't able to discuss her problems and suggests turning to someone else. Questioning shifts to S, who relates her childhood history in great detail. She also relates her sexual experiences and discusses her relationships with her parents. Q questions S about sexual experiences which (Q has learned from comments made by S on the ward) occurred at ten years with a forty-five year old man and at thirteen with another adult. S states that she has never talked about these before—that she was afraid to tell. S gives an account of the sexual experiences in question, and other group members laugh and act disturbed and finally are told to quiet down by S. S continues with discussion of her romance and marriage, and follows with the story of how her delusions began to develop and how these finally led to her commitment. *Atmosphere:* friendly with undercurrents of hostility. *Major Activity:* listening to and questioning Q and S. *Major Theme(s):* marital experiences of Q and S, and sexual experiences of S.

Session 4: S asks for volunteers. P asks if S wishes to continue. S continues talking about her childhood—relating her fantasies about her father. She continues with discussion about school and schoolmates and repeats the story of her commitment. Q asks about S's experiences in jail and about her general physical condition. S discusses how she felt while in jail and about her feelings while in the emergency hospital. Q presses for specific details and switches to pointed questioning about childhood sexual experiences. S becomes vague in her answers. O attempts to clarify the questions. Q demands that O "keep out of things." Q continues questioning S, attempting to trap her. O continues attempting to ease the tension. Q con-

tinues pressure, but S finally wiggles out. Q turns to N and questions her about sexual experiences. N insists she has already discussed them; Q is insistent and N begins talking somewhat reluctantly. She relates a sexual incident without interruption. *Atmosphere:* sometimes friendly, but always an undercurrent of hostility. *Major Activity:* listening to account offered by S, and pressuring S and N for accounts of sexual experiences. *Major Theme(s):* childhood and school experiences of S, and history of her illness.

Session 5: Q asks if N wishes to continue her story. N asks for information concerning what to talk about. Q does not volunteer information, and N discusses a romance. As story continues, N begins to introduce delusional material. O questions N concerning her real parents and then about her foster parents. N is evasive and introduces more delusional material. Q and S question N further about her parents. N becomes more confused, and begins to relate delusional material involving "Lewis and Clark" and "Hitler." Q questions this sharply. Discussion is continued with several group members attempting to point out delusional aspects of N's story. N is asked why she has never married. N offers a story about her education, work, and travel abroad. The validity of this story is questioned, and N becomes more confused. M questions N about a poisoning incident which N has related. N discusses this at great length, and Q questions her about details. A studio audience member asks N about her symptoms, pointing out that those cited by N are not symptoms of poisoning, and N shifts to saying she was drugged. S asks about the recreational activities of N; N discusses these. Q asks about details of commitment. N begins relating additional delusional material until the group turns the questioning to personal experiences. S demands that N begin with details of her childhood. N becomes reticent, and Q becomes encouraging and supporting. S turns to R and states that if she won't talk they will vote someone else to the table who will talk. *Atmosphere:* friendly and interested. *Major Activity:* questioning and challenging autobiographic account offered by N. *Major Theme(s):* N's story of life history and expression of her delusions.

Session 6: N continues the story of her employment with frequent instances of delusions. M interrupts and requests that she (M) be voted to staff. The vote is indeterminate and R questions the ward behavior of M, asking about incidents which took place while M was on parole. Q begins questioning M about her attitudes, her activities at home, how she will earn a living, etc. M becomes evasive, and her answers become shorter and shorter. M and R request a new vote on M. Q requests P to tell her story, but is interrupted by further demands for a vote. A long discussion ensues about proper round-table procedure, which is interrupted by P, who begins her story. Q and S question P at length about her family relationships and employment. P's answers become briefer. Q and S switch to questioning P about outbursts of anger and delusions of persecution. P is evasive and defensive. Q asks questions about school experiences, then about sexual experiences. P is evasive and refuses to answer any questions directly. M objects to Q's pressing the issue of sex. S attempts to divert Q, who becomes angry and harangues the group about the importance of sex, saying that they should be willing to discuss sexual problems freely. M and S remonstrate with Q and comments become general throughout the group. A disorganized discussion follows. Q interrupts by beginning to tell her own story, recounting childhood and religious experiences. *Atmosphere:* critical and hostile. *Major Activity:* inquisition of P and resistance to pressure by M for a vote to staff. *Major Theme(s):* M's present condition and P's autobiography.

Session 7: S asks P if she wishes to talk. P asks to be voted to staff. S states that the group doesn't know enough about her to be able to vote. P demands to know what they want to hear. S suggests an account of childhood experiences, but P is resistant to this. S states she is against P's going to staff. M questions P about her treatment at home and in the hospital. S questions P regarding her professed concern about her parents, and asks who is taking care of them now. P becomes defensive but attempts to justify her earlier comments. R asks that a therapist enter room and remove a studio audience member who is causing a disturbance. After the patient is removed, P's consideration for staff is brought up again and she is voted to staff with each member stating reasons for her vote. S asks Q to tell her story, which is interrupted by a studio audience member. S asks Q about details of her "nervous breakdown." Q begins to reply, and then shifts to her childhood experiences. She then begins to discuss her experiences and feelings in childbirth, stating that it was "disgusting and frightening." O asks about Q's childhood experiences which Q starts to answer, but M interrupts with further questions about Q's experience in childbirth. In subsequent discussion Q emphasizes the bloodiness of childbirth. O asks about Q's family relationships and Q discusses this. S asks leading questions about family relationships, and emphasizes the importance of Q's attitude toward her mother. M asks Q if her mother was partial; Q states that the whole family was partial to Q's twin sister. S suggests that Q is jealous. This Q

denies. Q relates her feelings of inferiority and her need to prove she is as good as anyone else. S continues effort to get Q to examine what she has said and to admit jealousy, etc. Q continues to evade this. Discussion continues around family relationships. *Atmosphere:* friendly, serious, and cooperative. *Major Activity:* first resisting and then yielding to pressure by P to be voted to staff; questioning Q's story. *Major Theme(s):* Q's childhood experiences and history of her illness.

Session 8: O requests a vote to staff. N asks O about her plans. Q suggests a vote on O. During the voting, which is indeterminate, O and Q engage in controversy about group leadership. Q becomes angry and O becomes evasive. S questions O about her prehospital and hospital experience. M turns to R and asks why she withdraws from the group. M, Q, and S attack R and ask why she can't or won't try to get along with others. O attempts to defend R. Then O and Q give R suggestions for improvement of her social relationships. R ignores this, and asks if the group wants her to go home. R's question is ignored, and discussion is continued concerning her lack of social graces. Q asks N about her childhood, which N answers evasively. S questions N about her allegations concerning poisoning incident in Europe. Q continues this discussion. N continues reciting symptoms and other reasons for believing that the poisoning took place. A studio audience member questions N about symptoms, relates symptoms from poisoning, and states that her symptoms don't fit. N agrees and says that's why she was sure she was drugged. S challenges this, but N makes rambling and indeterminate replies. Q suddenly switches to questions about the childhood of N. A studio audience member accuses N of having been pregnant—group members indignantly attack the studio audience member. N talks briefly about her childhood and then switches to an account of her school and work. Q asks about her parents. N says they have nothing to do with her problem. S states N is unwilling to talk about them. A studio audience member who has been heckling infuriates Q, who demands that she be voted from the room. The studio audience member comments about the "vulgar display of temper." S states that anger is sometimes good. S asks P about the "man who drugged you." P denies having said this. S states, "You may as well spill it here; when you get to staff they'll twist you up so much that you will anyway." Q becomes more enraged at the heckling of the studio audience member and gives the group a lecture about their stupidity and lack of cooperativeness. N suggests the group vote her out so that she can investigate why she was committed. Q questions the appearance of N, who states she has no reason for trying to look nice. Q asks N about her eating habits. Suggestions are made by group members as to how N might increase her appetite. The studio audience member asks if N is a communist sympathizer. N is evasive in answering. S questions R about her moral behavior, but R does not answer. *Atmosphere:* critical and impatient, occasionally friendly. *Major Activity:* pressuring N concerning her delusions and to elicit an autobiography. *Major Theme(s):* N's family, employment history, and delusions.

Session 9: S asks R why she will not sit down and eat on ward. R finally states she "doesn't deserve the food." S asks R why she will not associate with the rest of them. R says she doesn't feel like one of them, and asks if S does. A studio audience member is distracting the group and is voted from the room. O accuses Q and S of framing the group actions and dominating the table. S states that she can talk if she wishes. O continues hostilities until S says she can run things if she wishes. N asks M if, in becoming ill, she thought she was pregnant (referring to a delusional episode in M's history). M gives all the reasons why she thought she was, but stated she didn't know. She had gone to the hospital and been put in a "psychopathic" ward. O asks S about a belief formerly expressed by S that a nurse had killed her husband. S states she doesn't recall saying that and says that the newspaper had called her husband's death a suicide. Discussion follows about S's feelings at her husband's death. R is asked why she won't talk. R states she wants to get out of the hospital and talk to people about the hospital. S suggests she practice (talking) on round-table members. R continues to refuse to talk. There is discussion of voting R away from the table. S asks if R had ever been poisoned. R says she was poisoned. Q asks how she knows. R is evasive, stating that the food might merely have been spoiled. Q says she shouldn't have eaten it and R says she didn't. Q asks how she could have been poisoned if she hadn't eaten it. R protests that there isn't any reason to talk since the group can't understand her case. A discussion about cooperation in running of the group begins and many members ask questions. M asks to be allowed to tell her story from childhood. Q and S encourage her. M tells about her childhood, about her parents' relationships to her and to one another, and about her parents' divorce. Q questions M about details. S encourages all table members to ask questions. S questions M about her feelings on the death of her father. M says she isn't certain he is dead. Questioning continues until the group seems satisfied with answers. S compliments M on her honesty and cooperativeness and suggests that the other girls could do the

same. Various group members protest that they have told their stories. S says it's "awfully funny" that none of them have any worries and were never bothered by anything. Q suggests that they wouldn't be here if it weren't for some worry or difficulty. *Atmosphere:* generally hostile. *Major Activity:* competing for leadership, pressuring several members concerning delusions and concerning group and work behavior. *Major Theme(s):* M's family history, delusions of M and R, cooperativeness in the group.

Session 10: P is asked about her experience before the staff, and P says there isn't any reason for her talking since she won't get out anyway. S questions P about her feelings of sadness, then asks her about anger, which P denies, but finally admits. A general discussion about the reasons for losing one's temper follows. Q asks M when she was unhappy. M states that she was unhappy after her mother's death. Discussion follows about the happiest moments in each one's life, and about the saddest times. N mentions adolescence as an unhappy time, and Q begins questioning N for specific examples. N talks about her father and mother quarreling, then switches to naming various types of recreation. O asks what her saddest times were. S talks about when her father was away from home. Discussion turns to S's married life. S is asked why she chews her fingernails and replies that she does this as a way of expressing resentment. There is general discussion of the fact that everyone has peculiarities with suggestions that many people on the outside ought to be in the hospital. Q invites S to ask her questions. S asks if Q and her husband had enjoyed sexual relationships. Some group members laugh, and are reprimanded by S and Q. Q states that sexual relationships were painful. S brings up the subject of birth control. Q and O state that birth control is against their religion. S points out that there are many unwanted children. R asks if that (having an unwanted child) was the trouble with S. S denies this indignantly. R comments that "a person usually talks about what's uppermost in his mind." O and Q get into an argument about religion. O questions Q further about her sex relations. Q turns to S and asks if she has any further questions. *Atmosphere:* hostile and pressuring. *Major Activity:* questioning M, S, and Q concerning traumatic experiences and present behavior. *Major Theme(s):* staff experiences of P, family history of M, sexual experiences of Q.

Session 11: Q asks S to question her. S questions Q about sex relations. The discussion centers around the possibility of Q's remarrying her husband, how she would feel, what her family would think, how her children would be affected, etc. Q asks S to question her about her father. Various group members attack Q for her attitude toward attendants and other patients, and express displeasure at her talking to the nurse. S supports Q, finally stating that although group members want to vote one another home, they attack a girl who "talks sensibly." A vote on Q for staff is held, and goes against Q. S demands that members state reasons for their votes. Q counters resulting complaints by pointing out how she acts toward each member. Discussion switches to P's experience at staff. P says she told the truth but the staff wouldn't accept it. She relates her work experiences and brings in stories about "being drugged," being "attacked by men in her hotel room," etc. Much of this material is questioned, and P is asked what reason the staff gave her for not passing her. P evades this question and says that the staff wanted her to tell her story in detail. S encourages this, and P begins to tell her childhood experiences with feeling. Q questions her and sympathizes with her account of disappointments. P continues with an account of her adult life. Q and S compliment her and then attempt to decide what to do with a patient who was turned down at staff. *Atmosphere:* impatient and hostile. *Major Activity:* criticizing Q and defending votes against her, questioning P. *Major Theme(s):* Q's behavior in relation to her fitness for being voted to staff, P's delusions.

Session 12: The meeting opens with a discussion about what to do with patients turned down by the staff, and several suggestions are offered. A vote is called for and table members decide to retain "rejectees" at the table. The question of new table members arises and several new members are voted to come to the table when released patients leave. M asks S about her belief that her child was kidnapped. S suggests that her husband was "out of his mind" when he told her about this. There is argument as to whether S is well since she is confused about some things. Q keeps pressuring the group to send S home. The table finally votes S to staff. N questions O about her relationships with a family who employed her. O criticizes the family and accuses them of mistreating her. Q questions her story. O tells about her life after the birth of her children. M and Q ask about details of her illness; O states that everything in her hospital record is "reversed." Questions concerning O's relationship with her children and her attempts to support them are brought up. O becomes defensive. Q asks O why she "squawks" about the orphanage caring for her children, since O is unable to care for them. O replies that she doesn't want her daughter to be like Q who spent some time in an orphanage. S intercedes and questions O about her use of her money. M asks N to tell what her problem is. S

demands that N "wake up." R says that she has too much pride to live on the ward any longer. S suggests that she might as well go back to the audience then. N, Q, and S attempt to get R to talk but without success. *Atmosphere:* tense and hostile. *Major Activity:* considering S's fitness for release and voting her to staff, questioning O concerning her relationships with her children and plans for their care. *Major Theme(s):* S's delusions and O's difficulties.

APPENDIX D

Roles and Attitudes of Patients in Groups Selected for Intensive Study

(Male Patients)
(Dashes indicate inactivity except for participation in voting.)

Session No.	Patient: A		B*		C*		D		E	
	Role	Attitude	Role	Attitude	Role	Attitude	Role	Attitude	Role	Attitude
1	—	—					Questioner	Interested	—	—
2	Agitator	Aggressive					Initiator	Cynical	Questioner	Critical
3	—	—					Heckler	Resenftul	—	—
4	Observer	Indifferent					Clarifier	Friendly	—	—
5	Questionee	Cooperative					Questioner	Helpful	—	—
6	Questioner	Cooperative					Initiator	Eager	—	Concerned
7	—	—					Questioner	Heckler	—	—
8	Autobiographer	Cooperative					Autobiographer	Aggressive	—	—
9	Questioner	Interested					Questioner	Aggressive	—	—
10	Questioner	Supportive	Autobiographer	Eager	—	—	Questioner	Sarcastic	—	—
11	Voter	Interested	Defender	Defensive	—	—	Autobiographer	Hostile	—	—
12	Bored listener	Hostile	Questioner	Interested	—	—	Autobiographer	Domineering	Censor	Hostile
13	Autobiographer	Aggressive	Autobiographer	Subservient	—	Disinterested	(member of studio audience remaining sessions)		—	Interested
14	Questioner	Sympathetic	Questioner	Interested	—	—			—	—
15	Questioner	Sympathetic	Questioner	Aggressive	—	—			—	—
16	Questioner	Sympathetic	Questioner	Impatient	Questionee	Confused			—	—

* Member of studio audience until session 10.

(*Continued on next page*)

APPENDIX D—(continued)

(Male patients)
(Dashes indicate inactivity except for participation in voting.)

Session No.	Patient: F		G		H		I	
	Role	Attitude	Role	Attitude	Role	Attitude	Role	Attitude
1	—	—	—	—	Questioner	Sympathetic	Autobiographer	Cooperative
2	—	Withdrawn	—	Withdrawn	Questioner	Hostile	Moderator	Cooperative
3	—	Withdrawn	Questionee	Cooperative	Questioner	Friendly	Questioner	Friendly
4	—	Apathetic	Questionee	Cooperative	Questioner	Aggressive	Questioner	Friendly
5	—	—	Supporter	Helpful	—	—	Questioner	Interested
6	—	—	—	Disinterested	Advisor	Interested	Mediator, advisor	Friendly
7	—	—	Questioner	Interested	Questionee	Cooperative	Questioner	Sympathetic
8	—	—	Questioner	Supportive	Questioner	Interested	Autobiographer	Sincere
9	—	—	—	Interested	Questioner	Sympathetic	Supporter	Sympathetic
10	—	Evasive	Questioner	Supportive	(Discharged)		(Discharged)	
11	—	—	Peacemaker	Interested				
12	—	—	Censor	Hostile				
13	—	Disinterested	Questioner	Interested				
14	—	—	Autobiographer	Frank				
15	Questionee	Resistant evasive	Questioner	Sympathetic				
16	Questionee	Evasive hostile	Questioner	Concerned				

(*Continued on next page*)

APPENDIX D—(continued)

(Female patients)

(Dashes indicate inactivity except for participation in voting.)

Session No.	M		N		O		P		Q		R		S	
	Role	Attitude	Role	Attitude	Role	Attitude	Role	Attitude	Role	Attitude	Role	Attitude	Role	Attitude
1	Questioner	Friendly	—	—	Autobiographer	Defensive	Questioner	Supportive	Inquisitor	Critical	—	—	Questioner	Supportive
2	Questionee	Hesitant	Questionee	Hesitant	Questioner	Supportive	Questioner	Supportive	Inquisitor	Demanding	Questionee	Hesitant	Questioner	Supportive
3	Questioner	Interested	Questioner	Interested	Questioner	Interested	Questioner	Interested	Questionee	Evasive	—	—	Autobiographer	Frank
4	(absent)		Autobiographer	Annoyed	Mediator	Considerate	Initiator	Gentle	Inquisitor	Impatient	—	—	Autobiographer	Frank
5	Questioner	Interested	Autobiographer	Defensive	Questioner	Interested	Sgt-at-arms	Interested	Questioner	Aggressive	—	—	Questioner	Interested
6	Autobiographer	Defensive	—	—	Questioner	Interested	Autobiographer	Reticent	Inquisitor	Domineering	Autobiographer	Resistant	Questioner	Supportive
7	Questioner	Frank	Distractor	Disinterested	Questioner	Supportive	Autobiographer	Hostile	Autobiographer	Frank	Sgt-at-arms	Aggressive	Questioner	Considerate
8	Questioner	Friendly	Autobiographer	Evasive	Self-promoter	Petulant	Autobiographer	Defensive	Questioner	Domineering	Scapegoat	Apathetic	Mediator	Sympathetic
							Questionee							
9	Autobiographer	Cooperative	Questioner	Interested	Questioner	Rebellious	Questioner	Sympathetic	Questioner	Aggressive	Questionee	Superior	Questioner	Understanding
10	Questionee	Evasive	Questionee	Evasive	Questioner	Rebellious	Questionee	Evasive	Questionee	Hostile	—	—	Questionee	Supportive
11	Questioner	Interested	—	—	Questioner	Interested	Autobiographer	Defensive	Self-promoter	Aggressive	—	—	Defender	Supportive
12	Questioner	Interested	—	—	Questionee	Resistive	—	—	Questioner	Aggressive	Questionee	Evasive	Questionee	Frank

REFERENCES

1. DOLLARD, J., & MOWRER, O. H. A method of measuring tension in written documents. *J. abnorm. soc. Psychol.*, 1947, **42**, 3-32.
2. FROMM-REICHMANN, FRIEDA. The school and psychiatry. *Psychiatry*, 1948, **11**, xi-xii.
3. KLOPFER, B., & KELLEY, D. M. *The Rorschach technique*. Yonkers: World Book Company, 1946.
4. MCCANN, W. H., & ALMADA, A. Round-table psychotherapy: a technique in group psychotherapy. *J. consult. Psychol.*, 1950, **14**, 421-435.
5. MURRAY, H. A., *et al. Explorations in personality*. New York: Oxford Univer. Press, 1938.
6. POWDERMAKER, FLORENCE B., & FRANK, J. D. *Group psychotherapy*. Cambridge: Commonwealth Fund, 1953.
7. SHNEIDMAN, E. S. *Manual: Make-A-Picture-Story Test*. New York: The Psychological Corp., 1948.
8. SULLIVAN, H. S. *The interpersonal theory of psychiatry*. New York: Norton, 1953.
9. WECHSLER, D. *The measurement of adult intelligence*. (3rd Ed.) Baltimore: Williams & Wilkins, 1944.

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